P.T.M.
Healthcare Business Solutions

2022 External Quality Review

Annual Technical Report

Measurement Period: Calendar Year 2021
Validation Period: Feb-Nov 2022
Publish Date: Jan 24, 2023

MoHealthNet

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1.0 EXECUTIVE SUMMARY

1.1 Background

The Department of Social Services, Missouri HealthNet Division (MHD) is officially designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (CHIP)(Title XXI) programs. Missouri has an approved combination CHIP under Title XXI of the Social Security Act. Missouri's CHIP uses funds provided under Title XXI to expand eligibility under Missouri's State Medicaid Plan and obtain coverage that meets the requirements for a separate child health program. The MHD operates a Health Maintenance Organization (HMO) style Managed Care program called Missouri (MO) HealthNet Managed Care (hereinafter stated "managed care"). Managed care is extended statewide in four regions: Central, Eastern, Western, and Southwestern, to improve accessibility and quality of healthcare services to all the eligible populations while reducing the cost of providing that care. Participation in managed care is mandatory for the eligible groups within the regions in operation. Coverage under CHIP is provided statewide through the managed care delivery system.

The managed care program enables the MHD to provide Medicaid services to section 1931 children and related poverty-level populations; section 1931 adults and related poverty-level populations, including pregnant women; CHIP children; and foster care children. An amendment to the Missouri Constitution passed in August 2020 required the MHD to modify its Medicaid program to include low-income adults ages nineteen to sixty-four. The new population is called the “Adult Expansion Group (AEG).” The MHD began enrolling AEG in the managed care program effective Oct 1, 2021, under section 1932(a).

The MHD contracts with three managed care organizations (MCOs), also referred to as managed care plans (MCPs)/health plans, to provide health care services to its managed care enrollees. Home State Health, Healthy Blue, and UnitedHealthcare are the three MCOs operating in Missouri (Table 1-1). The MHD works closely with the MCOs to monitor quality, enrollee satisfaction, and contract compliance. Quality is monitored through various ongoing methods, including MCOs’ Healthcare Effectiveness Data and Information Set (HEDIS[1]) indicator reports, annual reviews, enrollee grievances and appeals, targeted record reviews, and an annual external quality review (EQR). None of the three MCOs are exempted from the EQR (42 Code of Federal Regulations (CFR) 438.364(a)(7)).

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 1-1. MCOs Operating under the MHD

	Home State Health	Healthy Blue	UnitedHealthcare
*Enrollees	334,747	378,903	298,069
MCO Location	11720 Borman Drive, St. Louis, MO, 63146	1831 Chestnut, St. Louis, MO, 63103	13655 Riverport Dr., Maryland Heights, MO, 63043
Audit Contact	Director, Compliance	Director, State Regulatory Affairs, Compliance Officer	Associate Director, Compliance

*Total 1,011,719-The MHD Managed Care Data as of June 24, 2022 (end of SFY 2022) for Medicaid, CHIP, and AEG. The increase in enrollment was 25.09% from the end of SFY 2021. Per the Centers for Medicare & Medicaid Services (CMS) enrollment trends snapshot, preliminary data comparing April 2022 to February 2020 show an overall increase in enrollment in Medicaid and CHIP for beneficiaries with full, comprehensive, and partial benefits by 20%, with the greatest percentage increases found in the pregnant, adult expansion, and adult eligibility groups. The increase in enrollment nationwide is largely attributed to the impact of the Covid-19 Public Health Emergency, in particular, the enactment of section 6008 of the Families First Coronavirus Response Act (FFCRA).

On Jan 1, 2018, the MHD contracted with Primaris Holdings, Inc. (Primaris), an External Quality Review Organization (EQRO), to conduct the EQR activities for five years. In the fifth year of the contract, Primaris ceased its operations. Primaris transitioned its EQRO contract to PRO Team Management Healthcare Business Solutions, LLC (hereinafter stated PTM) following all the legal requirements per the Office of Administration (OA), State of Missouri. PTM assumed all responsibilities for fulfilling the terms of the EQRO contract.

1.2 Overview of External Quality Review

An EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health services that an MCP, or its contractors, furnish to Medicaid beneficiaries (Figure 1-1). The review period for EQR 2022 is the calendar year (CY)/measurement year (MY) 2021. PTM conducted an EQR for the three MCOs, Home State Health, Healthy Blue, and UnitedHealthcare, utilizing the guidelines from 42 CFR 438.358; the EQR protocols established by the CMS in accordance with 42 CFR 438.352 (Protocols 1, 2, 3, and appendices A and B); the MHD Managed Care Contract; and the MHD Quality Improvement Strategy (QIS).

The EQR 2022 spanned from Feb-Nov 2022. PTM conducted the site visits to the MCOs' offices remotely due to the Covid-19 pandemic. The evaluation process included creating assessment tools, a desk review of policies and procedures, documentation, medical records, and interviews during the site meetings (Figure 1-2). In addition, technical assistance (TA) was provided during the review to help the three MCOs towards continuous improvement.

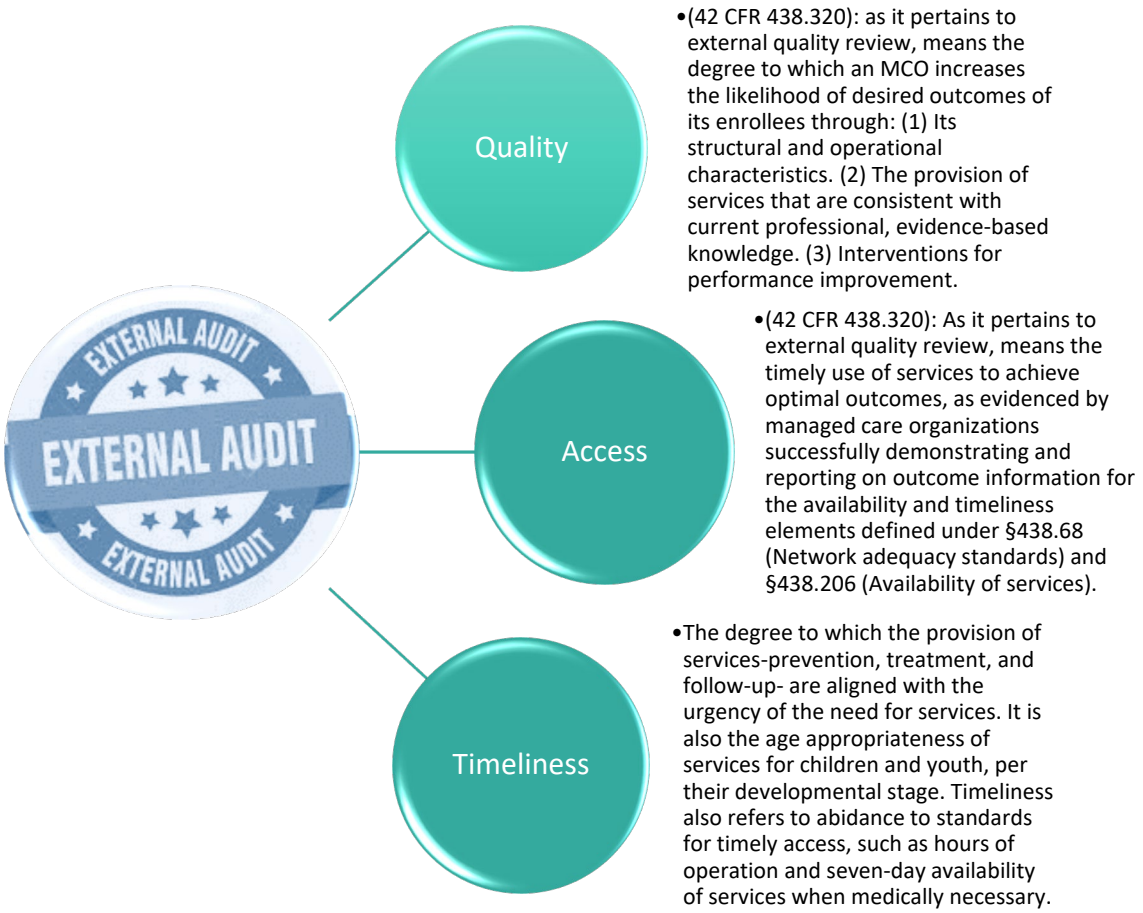


Figure 1-1. External Quality Review-A Federal Requirement

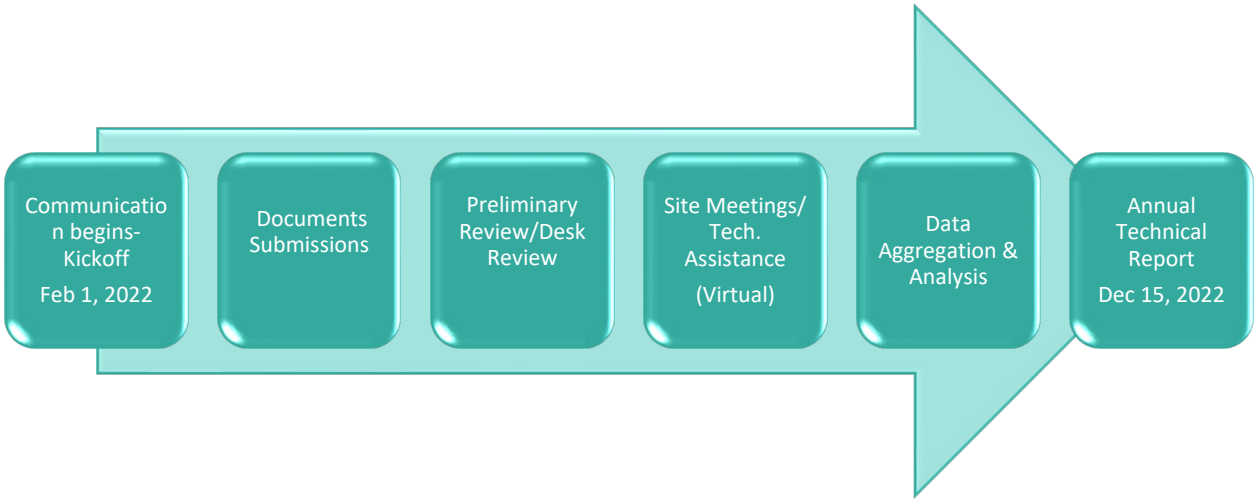


Figure 1-2 EQR Process for MCOs

To comply with the federal requirements in 42 CFR 438.364, PTM aggregated and analyzed the performance data for the following activities across the MCOs to prepare an Annual

Technical Report.
Mandatory Activities:

1. Validation of Performance Improvement Projects (PIPs).
2a. Validation of Performance Measures (PMs).
2b. Information Systems Capabilities Assessment (ISCA).
3. Review of Compliance with Medicaid and CHIP Managed Care Regulations.

Optional Activity: None.
Additional Activity: Care Management (CM) Review.

1.3 Overall Activities, Comparative Results, and Recommendations

This section presents an overview of all the activities conducted in EQR 2022 and comparative results across Home State Health, Healthy Blue, and UnitedHealthcare, including general recommendations from PTM.

1.3.1 Validation of Performance Improvement Projects

The MHD requires the MCOs to conduct performance improvement projects (PIPs) that focus on clinical and non-clinical areas each year as a part of their quality assessment and performance improvement (QAPI) program (42 CFR 438.330, 457.1240(b)/MHD contract, section 2.18.8 (d)):

- Clinical PIP: Improving Childhood Immunization Status (HEDIS CIS Combo 10 rate).
- Nonclinical PIP: Improving Oral Health (HEDIS ADV rate).

PTM followed the guidelines established in the CMS EQR Protocol 1 to validate the PIPs.

Comparative Results. Tables 1-2 to 1-4 summarize the clinical and the nonclinical PIPs across the three MCOs.

Table 1-2. PIPs Results Across MCOs

PIP	MCO	MHD's Aim	Validation Rating	HEDIS Rate % (MY 2020)	HEDIS Rate % (MY 2020)	Statistical Significance (P≤0.05)
Improving HEDIS CIS Combo 10 Rate	Home State Health	NM	No Confidence	26	26.3	No (p=0.81)
	Healthy Blue	NM	No confidence	36.01	30.41	Yes (>95% confidence interval)
	UnitedHealthcare	NM	No confidence	36.25	25.3	Yes (p=0.0002)

Improving Oral Health (HEDIS ADV Rate)	Home State Health	NM	No Confidence	41.39	42.31	Yes (p<0.00001)
	Healthy Blue	NM	No Confidence	44.18	44.93	Yes (>95% confidence interval)
	UnitedHealthcare	NM	No Confidence	41.18	42.39	Yes (p=0)

NM (Not Met-definition per EQR protocol 3). The rate in red indicates a decrease, and in green indicates an increase from the previous year.

Table 1-3. Summary of Clinical PIPs Across MCOs

PIP Title: Improving Childhood Immunization Status-HEDIS (CIS) Combo 10		
A. PIP Aim Statement		
Home State Health: Increase Home State Health's NCQA HEDIS Childhood Immunization Status (CIS) Combo 10 rate by 1% by December 31, 2021.	**Healthy Blue:** To achieve 2% points participation rate in the newly launched Healthy Rewards Influenza Incentives for eligible members, 2 years of age in MY 2021, by December 31, 2021. The goal of the PIP was to improve the rates of the most missed vaccine in the CIS Combo 10 series, thus improving the overall HEDIS CIS Combo 10 rate from 36.01% to 38.01% (2% points improvement) by HEDIS MY 2021.	**UnitedHealthcare:** By December 31, 2021, increase the percentage of UnitedHealthcare members aged 2 years and under who are eligible for and receive all CIS Combo 10 vaccines from 36.25% to 38.25%.
B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Member-focused. Pacify application (app) vendor was contacted to enhance the robustness of push notifications through the app to remind new moms of the importance of immunizations. Care managers re-education on the importance of	**Healthy Blue:** Member-focused. Healthy Rewards Member Incentive Program was launched from Aug 16-Dec 31, 2021, that offered a $10 reward for receiving the annual flu vaccination.	**UnitedHealthcare:** Member-focused. TTEC Live Agent Calling Program-Vendor calls to assist non-compliant members (turning 2 years by Dec 31, 2021) schedule CIS appointments in targeted six counties in MO.

addressing immunizations with new moms. Provider-focused. Incentivize providers to reach out and address member clinical gaps proactively.		
Sampling for intervention: Not reported	Sampling for intervention: Not reported	Sampling for intervention: Nonprobability (Judgmental/Purposive)
C. Was the PIP State-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (State required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the State) ☐ Plan choice (State allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☑ Children only (ages 0–17)* ☐ Adults only (age 18 and over) ☐ Both adults and children *If PIP uses different age threshold for children, specify age range here: Aged 0-2 years		
E. Target population description, such as duals, LTSS, or pregnant women (specify):		
Home State Health: The study population for the PIP included all Home State Health Medicaid members who turned 2 years of age during the measurement year who met the HEDIS eligibility requirements. The interventions were applied to all eligible members aged 0-2 years at the time of each intervention. The Medicaid population included TANF, CHIP, and Foster Care members. In addition, a targeted rapid cycle improvement initiative for High-Risk pregnant mothers and their newborns was included in this PIP.	**Healthy Blue:** The target population included all Healthy Blue members eligible for the statewide HEDIS CIS measure, as defined by the NCQA CIS HEDIS technical specifications. This consisted of all Healthy Blue members 2 years of age in MY 2021, who had 12 months of continuous enrollment prior to their 2nd birthday. No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's 2nd birthday was allowed to be considered continuously enrolled. The PIP study population included Healthy Blue members, 2 years of age in MY 2021, who were non-compliant for (had not received) the influenza vaccination as of August 2021.	**UnitedHealthcare:** The primary measure study population is defined by all UnitedHealthcare members who were eligible based on NCQA's HEDIS CIS Combo 10 technical specifications (8,376). For the secondary measure, the study population consisted of 3,631 members in Oct 2021 and ended with a final denominator of 3,528 for members who turned 2 years old in MY 2021 and were eligible based on NCQA's HEDIS CIS measure, who live in six specific Missouri counties.

F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP			
G. PIPs Validation Information			
• PIP submitted for approval • PIPs validated	☑Home State Health ☑PTM	☑Healthy Blue ☑PTM	☑UnitedHealthcare ☑PTM

Table 1-4. Summary of Nonclinical PIPs Across MCOs

PIP Title: Improving Oral Health-HEDIS Annual Dental Visit (ADV)		
A. PIP Aim Statement		
Home State Health: Increase Home State Health's CY 2020 NCQA HEDIS Annual Dental Visit (ADV) rate by 1% by December 31, 2021.	**Healthy Blue:** To increase the statewide HEDIS ADV rate from 44.18% to 46.18% (by 2% points) for members 2-20 years of age in MY 2021 by deploying a robust texting campaign to remind members of needed annual dental visits beginning May 21, 2021, and continuing through December 31, 2021.	**UnitedHealthcare:** By December 31, 2021, increase the percentage of UnitedHealthcare members between ages 2–20 years old who are eligible for and receive an annual dental visit from 41.18% to 43.18%.
B. Improvement Strategies or Interventions (Changes tested in PIPs)		
Home State Health: Member-focused. Home State Health's vendor, AlphaPointe, outreached to the noncompliant members for the annual dental visit via phone calls. Provider-focused. i. Home State Health collaborated with Affinia Healthcare, a large FQHC with three locations in the St. Louis area which offer dental care. The focus was on dental interventions in the St. Louis area for 2 to 9 years old, who were assigned to Affinia as their Primary Care Physician. ii. Home State Health partnered with Big Smiles,	**Healthy Blue:** Member-focused. Healthy Blue sent biweekly texts, up to six messages, to members or members' guardians eligible for the HEDIS ADV Measure (2-20 years of age in MY 2021) with a gap in care as of May 2021, reminding them to get their annual dental visit.	**UnitedHealthcare:** Member-focused. TTEC Live Agent Calling Program-Vendor calls to assist non-compliant members 4-6 years old schedule dental appointments in targeted three counties in Missouri.

which provided dental clinics in schools across Missouri.		
Sampling for intervention: Not reported	Sampling for intervention: Not reported	Sampling: Nonprobability (Judgmental/Purposive)
C. Was the PIP State-mandated, collaborative, statewide, or plan choice? ☑ State-mandated (State required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☑ Statewide (the PIP was conducted by all MCOs within the State) ☐ Plan choice (State allowed the plan to identify the PIP topic)		
D. Target age group (check one): ☐ Children only (ages 0–17) ☐ Adults only (age 18 and over) ☑ Both adults and children* *If PIP uses different age threshold for children, specify age range here: Aged 0-20 years		
E. Target population description, such as duals, LTSS, or pregnant women (specify):		
Home State Health: The study population was all members in the Medicaid population (inclusive of TANF, CHIP, Foster Care, and AEG) who met the eligibility criteria for the HEDIS ADV measure. The population was inclusive of members in all four regions. A targeted Rapid Cycle improvement initiative for members assigned to a specific FQHC in the Eastern region was included in this PIP.	**Healthy Blue:** The target population included all Healthy Blue members eligible for the statewide HEDIS ADV measure, as defined by the HEDIS ADV technical specifications. The PIP study population included Healthy Blue members, 2 years of age in MY 2021, who were non-compliant for (had not received) the influenza vaccination as of August 2021.	**UnitedHealthcare:** The study population for the primary measure consists of all UnitedHealthcare members who were eligible based on NCQA's HEDIS Annual Dental Visit (ADV) technical specifications. The criteria specify Medicaid members aged 2-20 years as of Dec 31, 2021, who are continuously enrolled throughout the measurement year with no more than one gap in enrollment as the eligible population. The population for the secondary measure and intervention included members eligible for the HEDIS ADV measure who were aged 4-6 years and who lived in Jackson County, Saint Louis County, and Saint Louis City.
F. Programs: Medicaid (Title XIX) only /CHIP (Title XXI) only/☑ Medicaid and CHIP		
G. PIPs Validation Information		

• PIP submitted for approval • PIPs validated	☑Home State Health ☑PTM	☑Healthy Blue ☑PTM	☑UnitedHealthcare ☑PTM

Recommendations. Home State Health, Healthy Blue, and UnitedHealthcare must refine their skills in developing and implementing approaches to affect change in their PIP methodology. The CMS EQR Protocol 1 and other resources from CMS, e.g., the How-to Manual for Health Plans (July 2015),[2] must be used for guidance. The MCOs must clarify the target population/project population/sampling/variables concepts and define and apply these in the PIPs. The data collection plan should be consistent with the data analysis plan, and Plan-Do-Study-Act (PDSA) cycles should be utilized to test the intervention. The demonstrated improvement should be linked to the quality improvement processes implemented, and intervention should tie to an improvement by correct analysis and interpretation.

1.3.2a Validation of Performance Measures

Federal regulations in 42 CFR 438.330(c) require states to specify standard performance measures for the MCOs to include in their comprehensive QAPI programs. PTM was required to determine whether the performance measures calculated by the MCOs were accurate based on the measure specifications and State reporting requirements (42 CFR 438.330(b)(2)). The MHD provided the performance measures to be validated, the specifications, and the requirements for reporting as identified in Table 1-5 below. PTM's analysis of the performance measures was based on CMS EQR Protocol 2, Validation of Performance Measures. The measurement period was Jan 1, 2021-Dec 31, 2021, and programs included were Medicaid, CHIP, and AEG.

Table 1-5. EQR 2022 Performance Measures

Performance Measure	Methodology	Specifications Used	Validation Methodology
Chlamydia Screening in Women (CHL)	Administrative	HEDIS	Primary Source Verification
Well-Child Visits in the First 30 Months of Life (W30)	Administrative	HEDIS	Primary Source Verification
Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days)	Administrative	HEDIS	Primary Source Verification

Comparative Results. PTM conducted primary source verification using a sample of 45

[2] https://www.medicaid.gov/medicaid/benefits/downloads/pip-manual-for-health-plans.pdf

numerator positive hits for all three measures for each MCO. All measures from the three MCOs were compliant and received a 'Fully Met' designation (Table 1-6).

Table 1-6. Key Review Findings and Audit Results: MCOs

Performance Measure	Sample Size	Key Review Finding (includes ISCA)	Audit Result
Chlamydia Screening in Women (CHL)	45 administrative numerator positives	No concerns were identified	Fully Met/ Reportable
Well-Child Visits in the First 30 Months of Life (W30)	45 administrative numerator positives	No concerns were identified	Fully Met/ Reportable
Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days)	45 administrative numerator positives	No concerns were identified	Fully Met/ Reportable

Chlamydia Screening in Women (CHL). All three MCOs reported CHL using the administrative methodology. MCOs still had some concerns about the impacts of the Covid-19 pandemic on the rates. However, each MCO performed better than the previous year. UnitedHealthcare had the highest rate (Table 1-7) (50.16%, an increase from 45.27% in the previous year), followed by Home State Health (47.63%, up from 45.92% in the previous year) and Healthy Blue (44.55%, up from 29.43% in the previous year). The difference in rates between Home State Health and UnitedHealthcare was insignificant. However, Healthy Blue's performance continued to be significantly lower than UnitedHealthcare (greater than 5% points difference in comparison) but not significantly lower than Home State Health. Healthy Blue also experienced the most significant yearly improvement, improving by 15.25% in MY 2021.

Table 1-7. Chlamydia Screening in Women (CHL)

Performance Measure: Chlamydia Screening in Women (CHL)			
Definition of Denominator: Women 16–24 years as of December 31 of the measurement year. The total rate is the sum of the age stratifications (16-20 years, 21-24 years).			
Definition of Numerator: At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.			
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. No concerns were identified.			
Data Sources Used: Administrative claims and supplemental data.			
Measure Detail	**Home State Health**	**Healthy Blue**	**UnitedHealthcare**
Numerator	6,842	7,258	5,304

Denominator	14,366	16,291	10,573
Rate	**47.63%**	**44.55%**	**50.16%**

Well Child Visits in the First 30 Months of Life (W30). The three MCOs provided final rates for the W30 measure based on services rendered in MY 2021. All three MCOs scored similarly, with UnitedHealthcare having the highest rate for the first 15 months (51.50%), followed by Healthy Blue (50.00%) and Home State Health (48.94%). Healthy Blue had the highest rate for the 15-30 months (61.18%), followed by UnitedHealthcare (59.29%) and Home State Health (56.35%). None of the MCOs' rates were significantly different based on the 95% significance test. Numerators, denominators, and rates are presented in Table 1-8 below.

Table 1-8 Well-Child Visits in the First 30 Months of Life (W30)

Performance Measure: Well-Child Visits in the First 30 Months of Life (W30)			
Definition of Denominator 1: Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days. **Definition of Denominator 2:** Children who turn 30 months old during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.			
Definition of Numerator 1: Six or more well-child visits on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. **Definition of Numerator 2:** Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.			
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. No concerns were identified.			
Data Sources Used: Administrative claims and supplemental data.			
Measure Detail	**Home State Health**	**Healthy Blue**	**UnitedHealthcare**
First 15 Months Numerator	5,100	6,206	4,535
First 15 Months Denominator	10,420	12,411	8,805
First 15 Months Rate	**48.94%**	**50.00%**	**51.50%**
15 – 30 Months Numerator	4,684	5,899	3,781
15 – 30 Months Denominator	8,313	9,641	6,377
15 – 30 Months Rate	**56.35%**	**61.19%**	**59.29%**

Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days). The three MCOs provided numerator positive claims for a random sample selected by PTM. During the virtual site review, PTM validated the numerator and denominator sets to ensure the original admission, and the follow-up visit was completed within 30 days of the original admission. PTM verified that the admission met the denominator requirements for diagnosis and service dates. Additionally, PTM reviewed the member's enrollment history to ensure the member was enrolled in the MHD managed care program during the MY. Numerator compliance was determined based on the visit type and provider specialty. All three MCOs met the numerator and denominator requirements for inclusion in the measure. There were significant differences found comparatively. Healthy Blue was shown to have the highest compliance (57.79%) compared to UnitedHealthcare (51.19%) and Home State Health (41.46%) (Table 1-9). Healthy Blue's compliance rate was 6.6% higher than UnitedHealthcare's and 16.33% higher than Home State Health's compliance rate. For this measure, higher rates indicate better performance.

Table 1-9. ***Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days)***

Performance Measure: Follow-Up After Hospitalization for Mental Illness – 30 days post-discharge (FUH-30 days)			
Definition of Denominator: The discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.			
Definition of Numerator: A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.			
ISCA Findings: Claims receipts were complete and timely, having all coding complete on claims. No concerns were identified.			
Data Sources Used: Administrative Mental Health Claims.			
Measure Detail	**Home State Health**	**Healthy Blue**	**UnitedHealthcare**
Numerator	1,180	1,824	1,099
Denominator	2,846	3,156	2,147
Rate	**41.46%**	**57.79%**	**51.19%**

Recommendations. The following general recommendations are provided for Home State Health, Healthy Blue, and UnitedHealthcare to improve their performances.

- The MCOs should continue to utilize telehealth services for their members. Telehealth services will eliminate the need for members to travel and perhaps eliminate any fears of being exposed during the Covid-19 pandemic.
- PTM recommends that the MCOs send reminders to members with children for

well-child visits. The MCOs should assist members with scheduling or rescheduling well-child visits.

- The MCOs discuss chlamydia screening protocol with all primary care providers. Sexually active members should be offered chlamydia screenings at the time of the visit.
- The MCOs utilize all viable supplemental data sources to enhance rates for chlamydia screening and well-child visits.
- PTM recommends that MCOs set up a follow-up visit for the member being discharged for mental illness within 30 days. The MCO should also follow up with the member to ensure the visit is kept or alternative telehealth services are available.

1.3.2b Information Systems Capabilities Assessment

PTM conducts ISCA pertaining to the validation of performance measures every year. Any change reported by Home State Health, Healthy Blue, and UnitedHealthcare that could impact information systems and related performance measure outcomes is evaluated each year. PTM followed CMS EQR protocols, Appendix A-Information Systems Capabilities Assessment, for guidance. Data collection, review, and analysis were conducted for each criterion via the ISCA data collection tools, interview responses, security walk-throughs, and claim/encounter data lifecycle demonstrations.

Comparative Results. None of the MCOs reported having significant changes to their information systems capabilities during the measurement year (Table 1-10). However, minor enhancements were made within the scope of the regular system maintenance schedule. Maintenance items included updates to the medical codes provided quarterly and annually (CPT-4, HCPCs, ICD-10).

Table 1-10. ISCA Findings: MCOs

Criteria	Home State Health	Healthy Blue	UnitedHealthcare
Data Integration	●	●	●
Data Control	●	●	●
Medical Service Data (Claims and Encounters)	●	●	●
Enrollment Data	●	●	●
Provider Data	●	●	●
Supplemental Data	●	●	●

●Fully Met/ ●Not Met

All MCOs reported that system backups and recoveries were not compromised during the measurement year. None of the MCOs reported a disaster requiring data restoration or recovery. System backups were done daily and nightly, with complete backups of data weekly. All MCOs had redundancy systems that would allow the restoration of critical data within two hours.

Healthy Blue fully integrated the former Missouri Care processes and systems into its own systems during MY 2021. Following a review of Healthy Blue's processing systems, PTM did not have any concerns related to performance measures.

Recommendations. There were no weaknesses identified. However, PTM recommends the following for further improvement to all the MCOs:

- All MCOs continue to routinely maintain/enhance system capabilities where efficiencies can be made.
- All MCOs review and enhance their security measures to ensure remote access is not compromised. In addition, regular testing of security should be conducted throughout the year.
- All MCOs regularly test for disasters and ensure data are secured offsite in case of emergencies.
- MCOs monitor changes to HEDIS measures and ensure servicing providers are aware of changes that may impact numerator compliance.

1.3.3 Review of Compliance with Medicaid and CHIP Managed Care Regulations

In reference to the 42 CFR 438.358(b)(1)(iii), a review must be conducted within a previous three-year period to determine an MCO's compliance with standards set forth 42 CFR 438, subpart D; 438.56; 438.100; 438.114; and 438.330 (total 14 regulatory standards). PTM conducted a review based on the CMS EQR Protocol 3. Seven regulations were evaluated in the EQR 2022, the second year in the current three-year review cycle (EQR 2021-2023). PTM initiated a corrective action plan (CAP) for the "Partially Met/Not Met" criteria for all three MCOs.

Comparative Results. Table 1-11 describes the compliance score obtained by the three MCOs in the current year (EQR 2022) and the previous two EQRs (2021-2020).

Table 1-11. Compliance Score (EQR 2022-2021-2020) Across MCOs

42 CFR 438 Medicaid	42 CFR 457 CHIP	Regulation	Home State Health Score %	Healthy Blue Score %	United Health care Score%	Year of Last Review
438.206	457.1230a	Availability of services	90	75	100	EQR 2022
438.207	457.1230b	Assurances of adequate capacity and services	82.1	53.6	60.7	EQR 2022
438.208	457.1230c	Coordination and continuity of care	100	86.8	92.1	EQR 2022
438.210	457.1230d	Coverage and authorization of services	94.7	89.5	76.3	EQR 2022
438.214	457.1233a	Provider selection	92.9	39.3	92.9	EQR 2022
438.224	457.1110	Confidentiality	93.2	86.4	97.7	EQR 2022
438.228	457.1260	Grievance and appeal system	85.3	82.4	91.17	EQR 2022
438.56	457.1212	Disenrollment: Requirements and limitations	94.4	86.1	100	EQR 2021
438.100	457.1220	Enrollee rights	77.8	72.2	86.1	EQR 2021
438.114	457.1228	Emergency and post-stabilization services	100	95.8	95.8	EQR 2021
438.230	457.1233b	Subcontractual relationships and delegation	91.7	91.7	83.3	EQR 2021
438.236	457.1233c	Practice guidelines	100	100	100	EQR 2021
438.242	457.1233d	Health information systems	93.8	65.6	56.3	EQR 2021
438.330	457.1240b	Quality assessment and performance improvement program	87.9	98.5	96.9	EQR 2020

Table 1-12 summarizes the noncompliance with all the regulations resulting in a CAP during the EQR 2022-2021-2020 across the MCOs.

Table 1-12. Noncompliance (EQR 2022-2021-2020) Across MCOs

42 CFR 438/457 Regulation	Home State Health CAP (Yes/No)	Healthy Blue CAP (Yes/No)	UnitedHealthcare CAP (Yes/No)
438.206/457.1230(a) Availability of services	Yes	Yes	No
438.207/457.1230(b) Assurances of adequate capacity and services	Yes	Yes	Yes
438.208/457.1230(c) Coordination and continuity of care	No	Yes	Yes
438.210/457.1230(d) Coverage and authorization of services	Yes	Yes	Yes
438.214/457.1233(a) Provider selection	Yes	Yes	Yes
438.224/457.1110 Confidentiality	Yes	Yes	Yes
438.228/457.1260 Grievance and appeal system	Yes	Yes	Yes
438.56/457.1212 Disenrollment: Requirements and limitations	Yes	Yes	No
438.100/457.1220 Enrollee rights	Yes	Yes	Yes
438.114/457.1228 Emergency and post-stabilization services	No	Yes	Yes
438.230/457.1233(b) Subcontractual relationships and delegation	Yes	Yes	Yes
438.236/457.1233(c) Practice guidelines	No	No	No
438.242/457.1233(d) Health information systems	Yes	Yes	Yes
438.330/457.1240b Quality assessment and performance improvement program	No*	No	No

*CAP was not initiated for "Partially Met" criteria in EQR 2020. However, in EQR 2021-2022, CAP was initiated for any noncompliant (Partially Met/Not Met) criteria.

Recommendations. The MCOs must submit the updated policies and procedures and supporting documentation for all the weaknesses noted during the review process,

including the "Not Met/Partially Met" scored criteria, within 90 days of CAP approval by the MHD, i.e., on Jan 5, 2023. PTM will evaluate and report them in the next EQR (2023). The documents should be updated based on the Medicaid and CHIP Final Rule 2020, and the MHD managed care contract effective July 1, 2022.

1.3.4 Review of Care Management Program

PTM conducted an annual review of the MCOs' CM programs following the guidelines provided in the MHD contract (version: Oct 1, 2021), sections 2.11.1 and 4.7.4 on CM requirements. The review included the identification of contributing issues and key drivers. The following CM focus areas were evaluated in the EQR 2022:

- Individuals in foster care, receiving foster care or an adoption subsidy, or other out-of-home placement (hereinafter referred to as Foster Care CM).
- Individuals with Autism Spectrum Disorder (Autism CM).
- Children with Elevated Blood Lead Levels (EBLLs CM).

Comparative Results. Table 1-13 compares the CM program results for Home State Health, Healthy Blue, and UnitedHealth under the following criteria:

Table 1-13. CM Program Performance Across MCOs

Criteria	Home State Health	Healthy Blue	UnitedHealthcare
Policies and Procedures for CM Program	Fully Met*	Fully Met	Partially Met
Medical Record Review (MRR)**	81%	84%	74%
Care Plan	Fully Met	Fully Met	Fully Met

*Definitions for fully met/partially met/not met were based on EQR protocol 3 for compliance.
**20 medical records were evaluated for each focus area.

Recommendations. The MCOs must collaborate with the MHD and Children's Division to receive placement information for the foster care population so that initial screening of members within 72 hours of placement can be done by the providers and tracked by the MCOs. The MCOs must conduct a comprehensive assessment within the timeframe set in the MHD contract. Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records. Primary Care Physicians (PCPs) must be provided written notification about case closure and condition at discharge.

2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

2.1 Objective and Technical Method

A PIP is a project conducted by an MCO designed to achieve significant improvement sustained over time in health outcomes and enrollee satisfaction. A PIP may be designed to change behavior at a member, provider, or MCO/system level.

The 42 CFR 438.358(b)(1)(i) requires an EQRO to conduct a validation of PIPs in accordance with 438.330(b)(1) that were underway during the preceding 12 months. Accordingly, PTM validated the two PIPs submitted by Home State Health, Healthy Blue, and UnitedHealthcare, and assessed whether the PIPs used sound methodology in their design, implementation, analysis, and reporting.

- Clinical PIP: Improving Childhood Immunization Status (HEDIS CIS Combo 10 rate).
- Nonclinical PIP: Improving Oral Health (HEDIS ADV rate).

PTM followed the guidelines established by the CMS EQR Protocol 1, Validation of PIPs. PTM referred to the MHD contract, section 2.18.8(d), for the requirements and confirmed the scope of work with the MHD. PTM requested the MCOs to upload its PIP documentation on PTM's web-based secure file storage site (AWS S3 SOC 2) by Aug 30, 2022. The review period for validation of the PIPs was Sept-Oct 2022. PTM requested additional information from the MCOs via electronic communication by Oct 7, 2022.

The MHD contract, section 2.18.8(d), requires the MCOs to increase HEDIS CIS Combo 10 and HEDIS ADV rates yearly by at least 2% points in alignment with the QIS. The MHD set the overarching aim for the PIPs. Vaccines and recommended doses in HEDIS CIS Combo 10 include DTaP (4); IPV (3); MMR (1); HiB (3); HepB (3); VZV (1); PCV (4); HepA (1); RV (2/3); and Flu (2).

The PIPs validation process included the following activities (Table 2-1):

Table 2-1. PIP Validation Process

Activity 1: Assess PIP Methodology	Step 1. Review the selected PIP topic. Step 2. Review the PIP aim statement. Step 3. Review the identified PIP population. Step 4. Review sampling methods (if sampling is used). Step 5. Review the selected PIP variables and performance measures. Step 6. Review data collection procedures: Administrative data collection, medical record review, and Hybrid data collection.

	Step 7. Review data analysis and interpretation of PIP results. Step 8. Assess the improvement strategies (Model for Improvement and PDSA process: rapid-cycle PIPs). Step 9. Assess the likelihood that significant and sustained improvement occurred.
Activity 2: Perform overall validation and reporting of PIP results	Level of Confidence: High; Moderate; Low; and No Confidence
Activity 3: Verify PIP findings	Optional (It will be conducted only if the MHD has concerns about data integrity and requires EQRO to verify the data produced by MCO.)

PTM assessed the overall validity and reliability of the PIP methods and findings to determine whether it has confidence in the results. The validation rating was based on the PTM's assessment of whether the MCOs adhered to an acceptable methodology for all phases of design (PIP topic, aim statement, selection of the population, sampling, selection of PIP variables and performance measures, selection of intervention-key driver diagram); data collection; data analysis; an interpretation of the PIP results; produced significant evidence of improvement based on a continuous quality improvement philosophy; and reflected an understanding of lessons learned and opportunities for improvement. (Statistically significant change in performance is noted when p value ≤ 0.05).

The level of confidence was defined as follows:

- High Confidence = The PIP was methodologically sound, achieved the SMART (Specific, Measurable, Attainable, Relevant, Time-bound) Aim, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- Moderate Confidence = The PIP was methodologically sound, achieved the SMART Aim, and some quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- Low Confidence = (A) The PIP was methodologically sound; however, the SMART Aim was not achieved; or (B) The SMART Aim was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- No Confidence = The SMART Aim of the PIP was not achieved, and the PIP methodology was not sound/acceptable.

PTM evaluated the degree to which the MCOs responded to EQRO's recommendations from the previous years' EQRs and categorized the MCOs' actions as follows:

- High: MCO fully addressed the recommendation, complied with the requirement, and PTM closed the item.
- Medium: MCO partially addressed the recommendation, the same recommendation applies, or a new recommendation is provided, and the item remains open.
- Low: Minimal action/no action was taken, the same recommendation applies, and the item remains open.

2.2 Findings, Analysis, and Conclusions: Home State Health

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description by Home State Health

This section of the report briefly describes the PIP design, intervention(s), and results submitted by Home State Health.

Intervention. For MY 2021, the following interventions continued as part of this PIP:
1. Care Management (CM) re-education on the importance of addressing immunizations with new mothers: PTM noted that Home State Health did not provide information to validate this intervention.

2. Home State Health contacted the Pacify application (app) vendor to enhance the robustness of push notifications through the app to remind new mothers of the importance of immunizations. Pacify is a pregnancy support app that members can download on their phones. A member must interact with CM staff to access the app to obtain an access code. Enrollment in CM was not required. The app provided live support with a Lactation Consultant, a direct line to our care management team, a direct link to the 24-Hour Nurse Advice Line, healthy pregnancy education postings, and push notifications for healthcare reminders, including well-child visits and immunization reminders. Home State Health provided this app at no cost to its pregnant members, focusing on enrolling High-Risk pregnant members. A High-Risk pregnant member was identified by the Pregnancy Risk Screening Tool (Notification of Pregnancy Form), which incorporated information provided by the member/provider and claims information to stratify a member into a Low, Medium, or High-Risk pregnancy based on proprietary pregnancy risk algorithms. The app was available to the pregnant member after delivery up to the child's first birthday in English and Spanish.

3. Provider Peak Performance Incentive: This program was an initiative to incentivize providers to reach out and address member clinical gaps proactively. Providers submitted

appropriate claims for services completed in November and December of 2021. The amount earned was in addition to standard provider pay-for-performance arrangements. Home State Health's provider support team communicated the program to all providers in the network. All received an email communication, and larger groups received the information during routine meetings with Home State Health. The target measures and incentives for MY 2021 included (Table 2-2):

Table 2-2. Provider Incentives MY 2021

Measure	Amount
Childhood Immunizations – Combo 10	$35
Lead Screening	$20
Well Care Visits Ages 3-11 Years	$30
Well Care Visits Ages 12-17 Years	$30
Well Care Visits Ages 18-21 Years	$30
Well Child Visits Ages 15 to 30 Months	$30
Well Child Visits First 15 Months of Life	$30

Performance Measure/Variable. NCQA HEDIS CIS Combo 10 was the performance measure selected for the PIP. The numerator and denominator were defined as follows:
Numerator: Home State Health members in the denominator who met the measure specification requirements for CIS Combo 10 as defined by the HEDIS technical specifications.
Denominator: Home State Health members who turned 2 years of age during the measurement year, were continuously enrolled for the 12 months prior to their second birthday with no more than a 45-day gap in enrollment.

Home State Health reported secondary measurements for CIS Combo 10 monthly rates; the impact of CM and Pacify app; Measles, Mumps, Rubella (MMR), and Hepatitis sub measures; and Provider Peak Incentive.

Data collection. Data was reported using Home State Health's NCQA-certified HEDIS software, QSI-XL. Input into QSI-XL was from various sources (claims data from Enterprise Data Warehouse, supplemental data (ShowMeVax portal), and medical records from the providers)

Findings. The data for the Pacify app intervention was divided into four categories:

- New moms who were utilizing the Pacify app and also enrolled in care management.
- New moms who were enrolled in care management but not using the Pacify app.
- New moms who were utilizing the Pacify app but not enrolled in care management.
- New moms who had neither the Pacify app nor were enrolled in care management.

Figures 2-1 and 2-2 below show the outcomes (MMR and Hepatitis A immunizations) within each category of member participation.

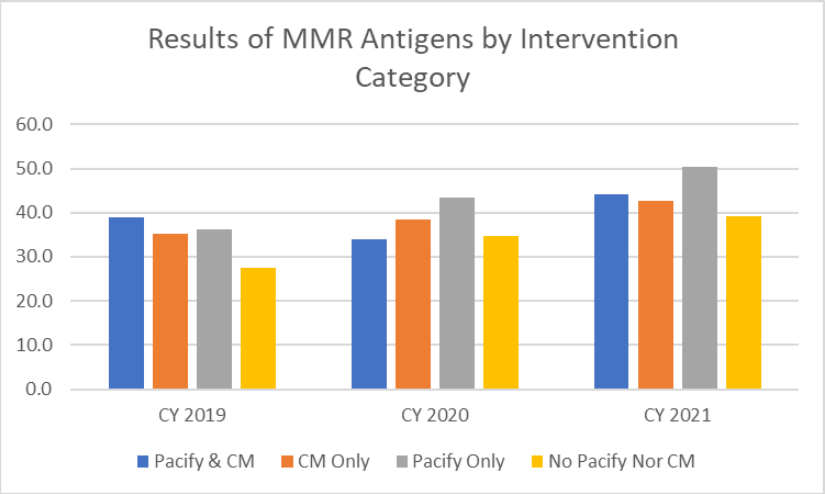


Figure 2-1. MMR Immunization Outcomes MY 2019-2021

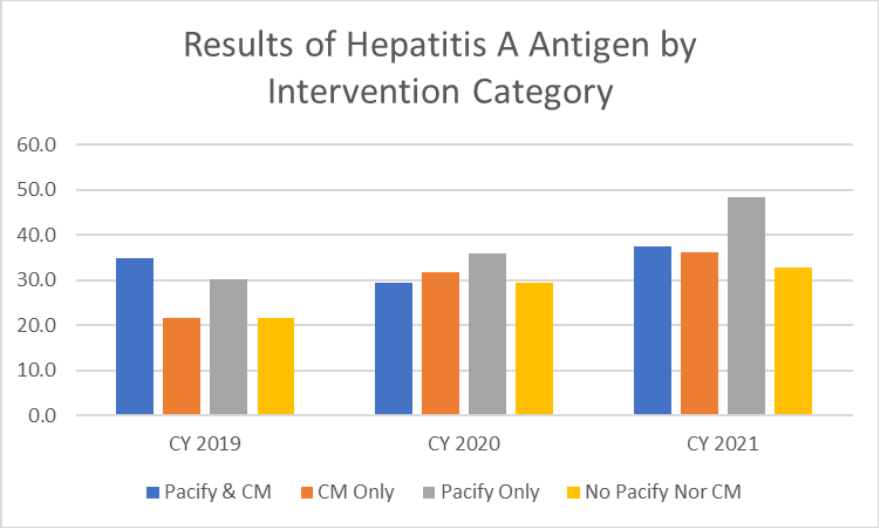


Figure 2-2. Hepatitis A Immunization Outcomes MY 2019-2021

Member satisfaction and utilization with the app were assessed to determine if members who had the app were utilizing it and were satisfied with the service. In MY 2020, Home State Health received 150 responses to a satisfaction survey and scored 4.9 out of 5 Stars. In MY 2021, Home State Health received 183 responses to the satisfaction survey resulting in 4.9 out of 5 Stars.

Provider Peak Incentive: The results were analyzed after the incentive period closed (and allowed for claims run-out). A total of 15 unique providers earned incentives by closing the gaps for 23 members. Home State Health stated that this intervention had a 0.22% impact on the overall HEDIS CIS Combo 10 rate.

Figure 2-3 tracks monthly administrative HEDIS CIS Combo 10 and final hybrid rates for MY 2019-2021. MY 2021 began with a 5.83% lower rate than MY 2020 and remained lower throughout the year (administrative rates).

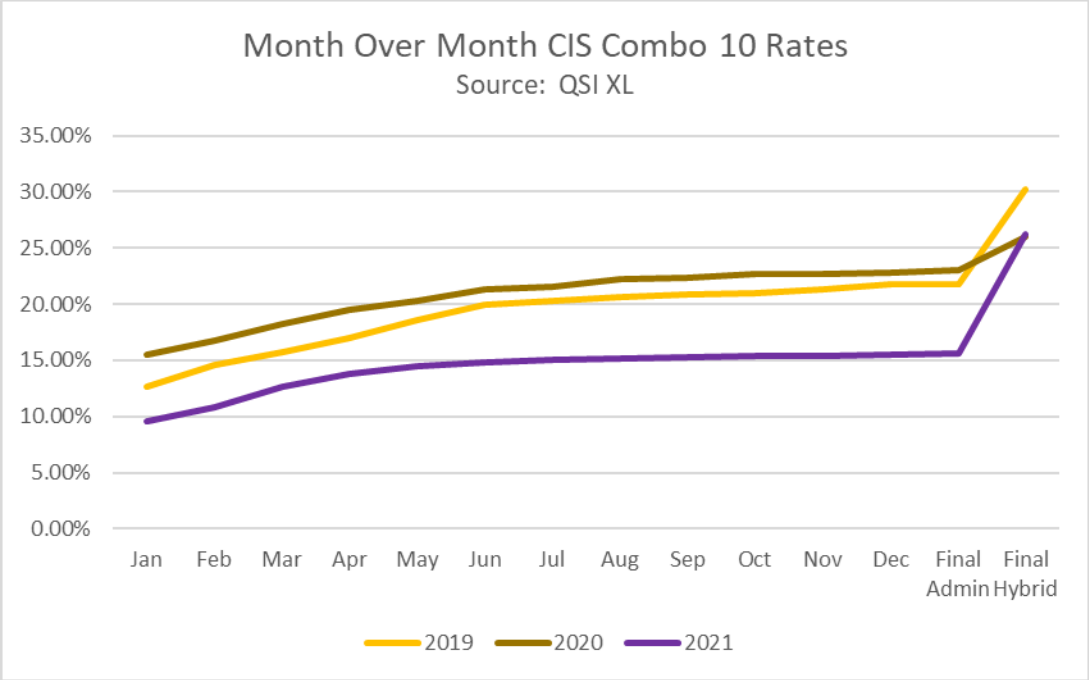


Figure 2-3. Monthly HEDIS CIS Combo Rates (MY 2019-2021)

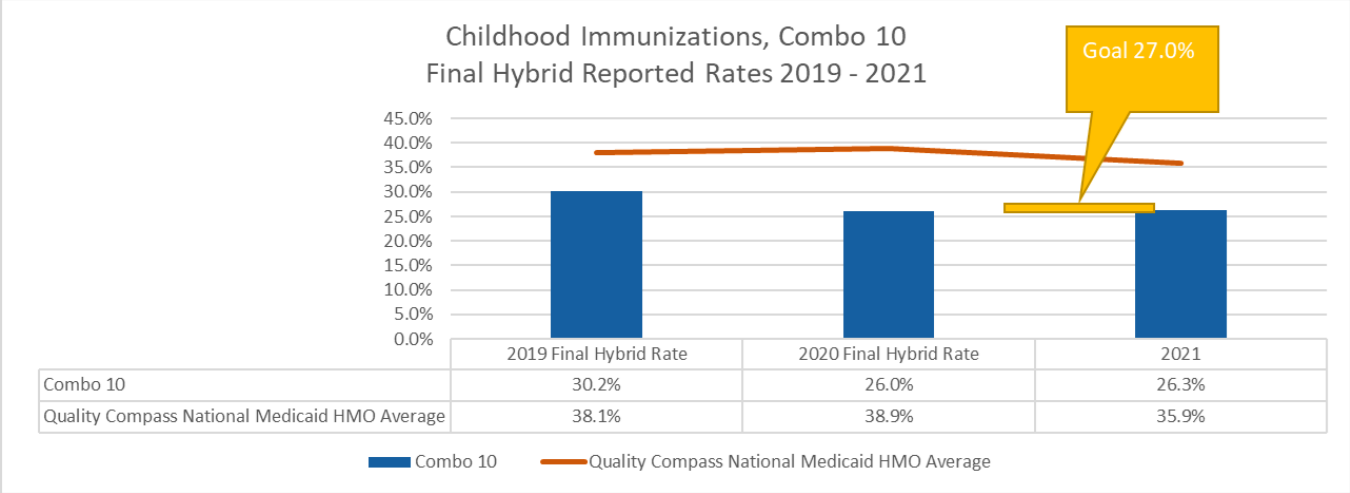


Figure 2-4. HEDIS CIS Combo 10 Final (Hybrid) Rates: MY 2019-2021

PIP Result

Home State Health did not meet the aim to increase the HEDIS CIS Combo 10 rate by 2% points from the previous year. The final HEDIS CIS Combo 10 rate (hybrid) marginally

increased from 26% (MY 2020) to 26.3% (MY 2021) by 0.3% points (Figure 2-4). This increase was not of statistical significance (P=0.81034).

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description by Home State Health

This section briefly describes the PIP design, intervention(s), and results submitted by Home State Health.

Interventions.

1. Statewide Initiative: AlphaPointe is a sheltered workshop in the Kansas City area that performs various outreach campaigns to Home State Health members to assist with understanding their benefits (incentives and transportation), schedule health care appointments, and perform screenings. Home State Health contacted AlphaPointe in the fourth quarter of MY 2019 to request a targeted outbound call campaign for noncompliant members' annual dental visits. AlphaPointe intervention again began making the dental outreach calls in October 2020 and continued in MY 2021. The calls were made throughout the year.

2. Eastern Region Initiative: In Quarter 3-MY 2020, Home State Health collaborated with Affinia Healthcare, a large FQHC with three locations in the St. Louis area which offer dental care, to focus on dental interventions in the St. Louis area. The goal of this partnership was to increase the compliance rate on the ADV measure for Home State Health members, 2 to 9 years old, who were assigned to Affinia as their Primary Care Physician. Home State Health took the following actions:

- Demographic information was exchanged between Affinia and Home State Health to determine the most recent demographic information on file to better locate Home State Health members.
- Home State Health sent dental text reminders/education messages to members assigned to Affinia as their PCP who were noncompliant with their dental visit.
- Affinia sent dental text reminders/education messages to their assigned members who were noncompliant with their dental visits.
- Affinia re-educated their frontline staff and scheduling team to remind them to address dental appointments and benefits information with members.
- Home State Health supplied additional brochures, including member incentives and transportation information for the Affinia staff to reference and give to its members.
- Home State Health donated personal protective equipment (PPE) to Affinia for their staff and members.

The Affinia intervention continued in MY 2021. Based on the lower-than-desired results,

Affinia called non-compliant members to educate these members about needing a dental visit, benefits, and member incentives during their outreach versus texting the previous year. In addition to education, Affinia offered two dental day clinic dates for non-compliant members to attend.

3. Big Smiles School-Based Clinics and Text Campaign: In the last quarter (Q4) of MY 2021, Home State Health partnered with Big Smiles, which provides dental clinics in schools across the MO. The intent was to encourage dental visits for school-age children if the children attended a school in which Big Smiles held a clinic. A mobile health engagement company (mPulse) was engaged to send text messages through their mobile channel platform. The texts were sent to member guardians within the counties and zip codes in which Big Smiles was hosting a school-based clinic. Weekly text messages were sent each Thursday beginning in Q4-MY 2021.

Performance Measure. NCQA HEDIS ADV was the performance measure selected for the PIP. The numerator and denominator were defined as follows:
Numerator: Home State Health members in the denominator who had one or more dental visits with a dental practitioner during the measurement year.
Denominator: Home State Health members aged 2 through 20 years enrolled on December 31 of the measurement year, who were continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year.

Home State Health reported secondary measurements for the following:
1. AlphaPointe Contact Rates and Compliancy Post-Contact: This measurement was used to track the AlphaPointe successful contact rate. The rate of members contacted who became compliant post-contact by AlphaPointe was also tracked.
Numerator: The number of members in the denominator whom AlphaPointe reached live by phone contact. AlphaPointe provided a weekly call report to Home State Health of the details of their outreach, including attempts and successful contacts.
Denominator: Members in the denominator but non-compliant. Data is queried from Inovalon's QSI XL system with each outreach and posted for AlphaPointe.

The percentage of members successfully contacted who became compliant:
Numerator: Members who are compliant after the successful outreach.
Denominator: Members successfully outreached to per AlphaPointe data.
2. Affinia Compliance Rate: The compliance rate is calculated based on the percentage of Affinia's Home State Health panel compliant for the HEDIS ADV measure.
Numerator: Members in the denominator who are compliant, per Inovalon QSI XL.
Denominator: Members assigned to Affinia's Tax Identification Number (TIN), sourced

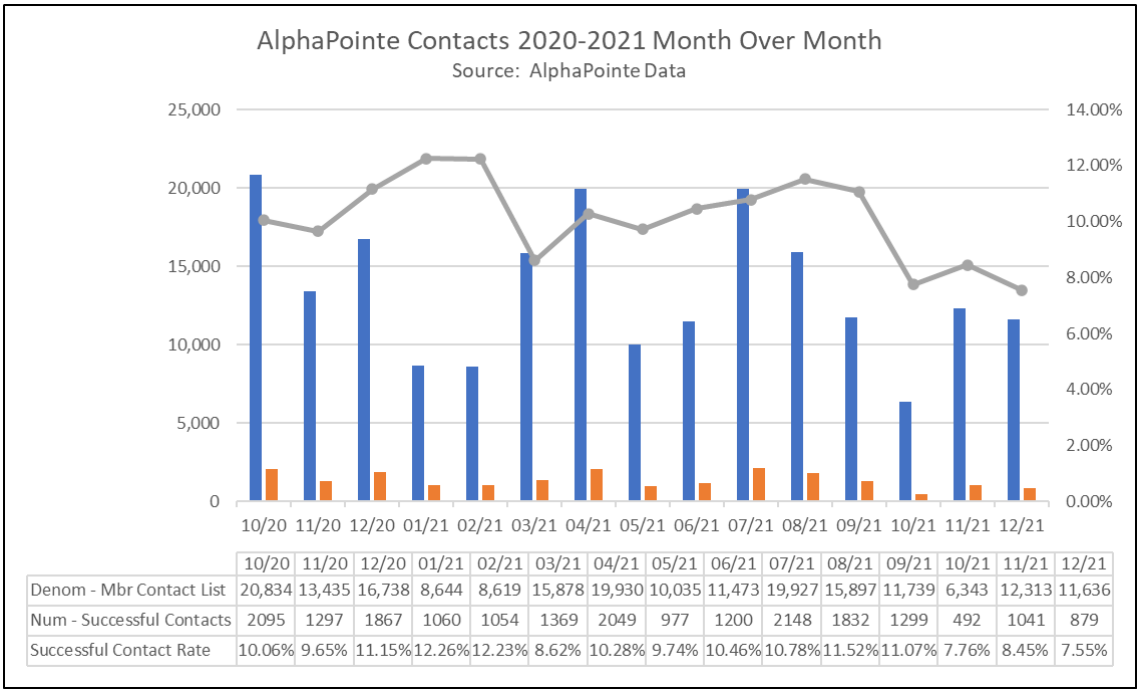
from Home State Health's system to assign, and track member PCP assignments (Unified Member View or UMV, queried from the electronic data warehouse)

3. Big Smiles School-Based Clinics and Text Campaign: Rate of compliant members who received a text to analyze the intervention.

Data Collection. HEDIS ADV was reported using NCQA-certified HEDIS software, QSI-XL. The rate was reported annually and also tracked monthly for variation and progress. AlphaPointe provided a weekly call report to Home State Health of the details of their outreach, including attempts and successful contacts. Affinia compliance rate was calculated monthly per Inovalon QSI XL.

Findings.

Intervention 1 (AlphaPointe): AlphaPointe was given a list of 152,434 members to call throughout MY 2021 and successfully contacted 15,400 (10.10%). AlphaPointe made more calls in MY 2021 versus MY 2020 with the same rate of successful contacts (calls where they reached a member). Figure 2-5 shows successful contacts monthly during MY 2021.



	10/20	11/20	12/20	01/21	02/21	03/21	04/21	05/21	06/21	07/21	08/21	09/21	10/21	11/21	12/21
Denom - Mbr Contact List	20,834	13,435	16,738	8,644	8,619	15,878	19,930	10,035	11,473	19,927	15,897	11,739	6,343	12,313	11,636
Num - Successful Contacts	2095	1297	1867	1060	1054	1369	2049	977	1200	2148	1832	1299	492	1041	879
Successful Contact Rate	10.06%	9.65%	11.15%	12.26%	12.23%	8.62%	10.28%	9.74%	10.46%	10.78%	11.52%	11.07%	7.76%	8.45%	7.55%

Figure 2-5. AlphaPointe Success Contact Rate Monthly

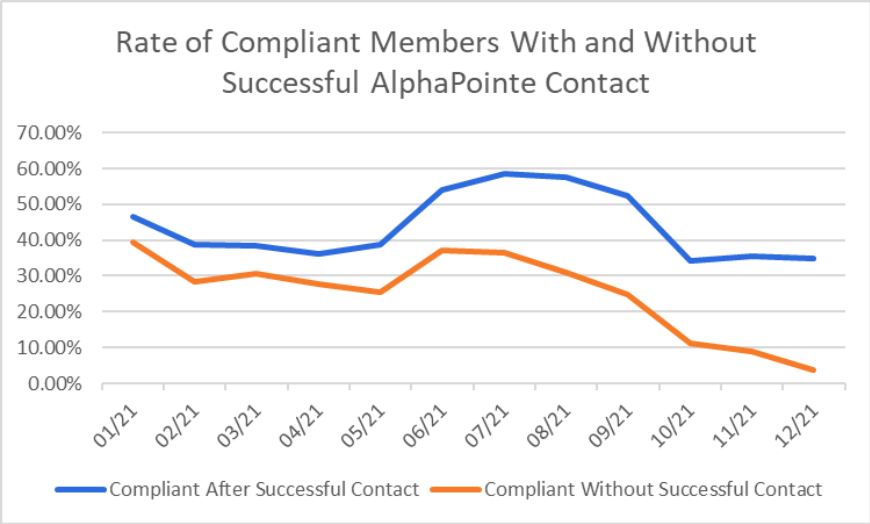


Figure 2-6. AlphaPointe Compliance Rate MY 2021

Home State Health reported the compliance rate of those members who were successfully contacted versus members who were called but did not have a successful contact throughout MY 2021 (Figure 2-6). For the 10.10% of members who were successfully contacted, the average compliance with ADV was 45.61%.

Intervention 2 (Affinia): In MY 2021, Home State Health provided a list of 3,048 ADV non-compliant members to Affinia to increase compliance. These members were assigned to an affiliated Affinia Primary Care Provider. Affinia conducted an outreach campaign to those members to encourage attendance in one of two clinics offered during the year. As a result, out of 3,048 members, 41 became compliant after attending an Affinia Dental Day (Table 2-3).

Table 2-3. Affinia Dental Days: MY 2021

Affinia Dental Dates	2.24.2021	8.28.2021
Total Affinia Non-Compliant ADV Members Provided (Aged 2-20 years)	3,048	2,831
Total Affinia Compliant ADV Counts - Based on Flowchart Runs Post Dental Days	493	316
Count of Schedule Members	20	21
Compliance Percentage Outcomes - Based on Scheduled Members	4.1%	6.6%

Intervention 3 (Big Smiles): Home State Health provided mPulse with a list of 19,254 ADV

non-compliant members to send text messages. Of the 19,254 outreach attempts, 1,019 (5.29%) resulted in compliant dental visits by the end of the measurement year (Table 2-4).

Table 2-4. Big Smiles Outcomes MY 2021

Text Date	Compliant After Text Message	Compliant Before Text Message	Member Lost Eligibility/Not in Denominator	No Change in Compliance
11.22.21	177	615	111	1059
12.14.21	356	4125	423	5352
12.2.21	230	1164	265	1766
12.6.21	256	1299	204	1852
Total MY 2021	1019	7203	1003	10029

Figure 2-7 tracks monthly administrative HEDIS ADV and final rates for MY 2019-2021.

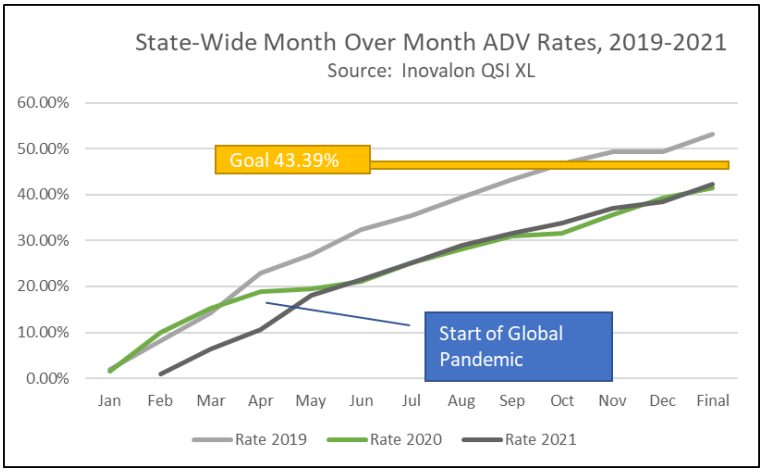


Figure 2-7. HEDIS ADV Rates Monthly (MY 2019-MY 2021)

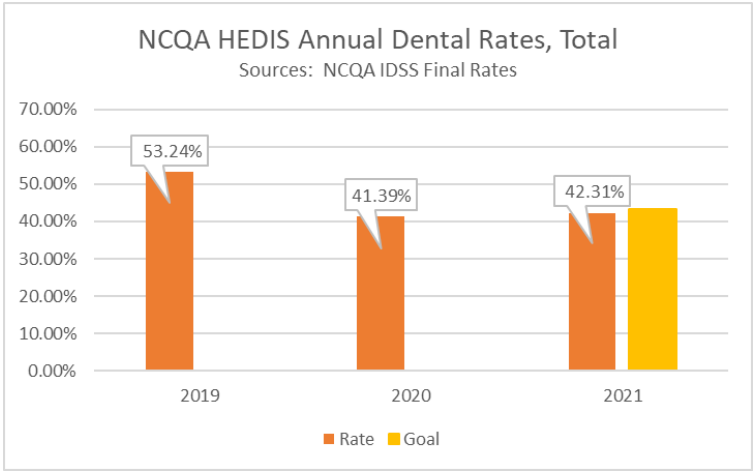


Figure 2-8. HEDIS ADV Rates Annual (MY 2019-2021)

PIP Result

Home State Health did not meet the aim to increase the HEDIS ADV rate by 2% points from the previous year. However, the HEDIS ADV rate increased from 41.39%% (MY 2020) to 42.31% (MY 2021) by 0.92% points which was of statistical significance (P<0.00001) (Figure 2-8).

2.2.1 Quality, Timeliness, and Access

PIPs Score. Home State Health did not meet the MHD's goal to increase the HEDIS CIS Combo 10 and HEDIS ADV rates by 2% points from the previous year. Also, the PIP methodology was not sound, so PTM assigned a score of "no confidence" for both clinical and nonclinical PIPs.
The PIPs did not meet all the required guidelines stated in the 42 CFR 438.330(d)(2)/MHD contract, section 2.18.8(d)(1) (Table 2-5).

Table 2-5. PIPs' Evaluation based on the CFR/MHD Guidelines

CFR Guidelines	CIS PIP	ADV PIP
Measurement of performance using objective quality indicators	Partially Met	Partially Met
Implementation of system interventions to achieve improvement in the access to and quality of care	Not Met	Not Met
Evaluation of the effectiveness of the interventions	Not Met	Not Met
Planning and initiation of activities for increasing or sustaining improvement.	Fully Met	Fully Met

Strengths and Weaknesses. PTM identified the following strengths and weaknesses in the validation process of both the PIPs, summarized in Table 2-6.

Table 2-6. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic	N/A (the MHD provided the topic, hence marked as Not/Applicable-N/A)	Even though the MHD selected the topic, Home State Health did not clarify if its PIPs included all members with special health needs and services.
2. Writing an Aim statement		The Aim statement was incomplete and inaccurate. It did not specify the improvement strategy, the

Evaluation Criteria	Strength	Weakness
		population, and the correct goal as required by the MHD.
3. Identifying the study population		Home State Health lacks clarity on what constitutes the target population and the project population. As a result, multiple statements about the study population were provided.
4. Sampling		PTM determined that Home State Health utilized a non-probability sampling methodology (Judgmental/purposive) in the nonclinical PIP. However, Home State Health did not identify or report it.
5. Variables/performance measures (the MHD decided the primary measure)		Variables were not used in the PIPs. For the clinical PIP, MMR vaccination rate and Hepatitis A vaccination rate were selected as sub-measures even though the intervention was not specific to these measures. For the non-clinic PIP, the secondary measures were not accurately defined (numerator, denominator, units).
6. Data collection procedures		The PIP design did not include a data collection plan, all sources of data, and frequency for data collection.
7. Data analysis and interpretation of results		The baseline and the measurement year data did not correspond to the same parameter for the interventions. A baseline rate before the start of an intervention followed by at least two remeasurements was not presented for all

Evaluation Criteria	Strength	Weakness
		interventions. The PIP design did not analyze and incorporate lessons learned during the intervention at each measurement. PDSA cycles were not implemented.
8. Improvement strategies		The improvement strategies failed to achieve the PIP's aim for both PIPs. Clinical PIP: All the patient groups (with or without the Pacify app) showed an increase in the Hep A and MMR rates in MY 2021 though the administrative data for HEDIS CIS Combo 10 in MY 2021 was lower than the rate in MY 2020 for each corresponding month during the intervention. Nonclinical PIP: The AlphaPointe successful contact rate was 10.10% of members who are non-compliant and achieved a compliance rate of 45.61% of these 10.10% members. Affinia intervention closed less than a 1% gap of the denominator. The Big Smiles intervention compliance rate was 5.29%. The PIPs did not provide information on whether the improvement strategies selected for the PIPs were evidence-based and the test of change that would likely lead to the desired improvement in process or outcomes. The strategies were not designed to

Evaluation Criteria	Strength	Weakness
		address the intervention's root cause or barrier to poor results. The effectiveness of the improvement strategies was not determined by measuring a change in performance according to a predefined target or aim.
9. Significant and sustained improvement		The final HEDIS CIS Combo 10 administrative rate did not show any improvement in MY 2021 compared to MY 2020. However, the final hybrid HEDIS CIS Combo 10 rate increased by 0.3% points, which was statistically insignificant. The final HEDIS ADV rate showed a statistically significant increase of 0.92% points (MY 2021-42.31%, MY 2020-41.39%). None of the two PIPs achieved the aim of increasing the HEDIS rates by 2% points from the previous year.

2.2.2 Improvement from previous year

Table 2-7 shows the degree to which Home State Health responded to EQRO's recommendations from the previous years' EQRs and PTM's new recommendations applicable in the current EQR 2022. (Refer to Table 2-6 for Home State Health's performance in EQR 2022.)

Table 2-7. Degree of response to EQRO's previous recommendations

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
EQR 2021		
1. Aim Statement: The PIP aim statement should define the	Home State Health did not define the aim statement	**Low**

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
improvement strategy, population, and period. It should be clear and concise, measurable, and answerable.	accurately. As a result, the issue remained in the EQR 2022.	The same recommendation applies to the EQR 2022.
2. Study Population: Home State Health should articulate the concepts and clearly define the target population and PIP population. The PIP population should be selected at a small scale (e.g., from a county, provider office, or region) so that results can be measured during the PDSA cycle and subsequently applied at a larger scale.	The recommendation was not implemented. The issue remained in the EQR 2022.	**Low** The same recommendation applies to the EQR 2022.
3. PDSA Cycles: Home State Health must adopt PDSA cycles that involve analysis, feedback/lessons learned from the data collected after the intervention, and application of these outcomes to plan another test cycle.	Though Home State Health reported using the PDSA cycles for both the PIPs, PTM determined that the process was not followed.	**Low** The same recommendation applies to the EQR 2022.
4. Data Analysis and Interpretation of Results: Though conclusive demonstration through controlled studies is not required, Home State Health should compare the results across multiple entities, such as different patient subgroups and provider sites, to ascertain the change brought by the intervention.	Home State Health compared different patient groups for clinical PIP and non-clinical PIP.	**Medium** The same recommendation applies to the EQR 2022.
5. Sustained improvement: After an intervention is implemented and results are analyzed, Home State Health should identify strategies to create a sustained improvement. This allows Home State Health to maintain the positive results of the intervention, correct negative	Home State Health continued the interventions from the previous year even though they did not demonstrate improvement and decided to implement them the following year.	**Low** The same recommendation applies to the EQR 2022. In addition, a target should be set for the intervention based

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
results, and scale the intervention to support longer-term improvements or broader improvement capacity across other health services, populations, and aspects of care. Because PIPs can be resource-intensive, this phase also helps learn how to allocate more efficiently for future projects.		on the goal of the PIP. The intervention should be adopted, adapted, or abandoned with each PDSA cycle based on the results obtained.
EQR 2020		
1. While several/ongoing interventions from previous years are very informative, Home State Health should present the interventions applied for the PIPs rather than for statewide or corporate-wide operations.	There was some improvement. Home State Health reduced the details of other interventions outside the PIP operating in MO.	**Medium** The same recommendation applies to EQR 2022. Home State Health should focus on the steps involved in the PIP methodology.
2. Even though the MHD mandates an overarching goal, Home State Health can select a topic within specified parameters. To ensure a successful PIP, Home State Health should find early and regular opportunities to obtain input from staff, providers, and members, improving care delivery.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to the EQR 2022.
3. Home State Health should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle). PIP population should be selected from a county, provider office, or region so that results can be measured during the PDSA cycle and subsequently applied on a larger scale.	There was some improvement towards this step in the methodology of PIP in EQR 2022. One of the interventions in the nonclinical PIP was in one region).	**Medium** The same recommendation applies to EQR 2022.

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
4. Home State Health should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify Home State Health's performance on the PIPs and track improvement over time. Home State Health can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary measures or supplement the overall measurement set, providing information that will aid PIP planning and implementation.	There was some improvement towards this step in the methodology of PIP in EQR 2022. The variables were not selected, but secondary measures were selected; however, they were inaccurately defined and applied in the PIPs. Moreover, qualitative measures were not used.	**Low** The same recommendation applies to the EQR 2022.
5. Home State Health should use variables/secondary measures that tie an intervention to improvement. Clear and concise definitions of data elements (including numerical definitions and units of measure) should be provided for the data collected after the intervention.	Same comment as above.	**Low** The same recommendation applies to the EQR 2022.
6. Data collection plan should be linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to the EQR 2022.
7. A baseline rate should be presented before the start of an intervention, followed by at least two remeasurements. Analysis of results should be utilized to plan the subsequent intervention (cycle-PDSA) for future PIP. Additionally,	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to the EQR 2022.

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
primary and secondary measures/variables should be linked to illustrate the impact of the intervention on a project's performance.		
8. Home State Health should assess whether the PIP resulted in sustained improvement, whether repeated measurements were conducted, and if so, whether a significant change in performance relative to baseline measurement was observed. Repeat measurements (at least two) in short intervals should be conducted to determine whether significant performance changes relative to baseline measurement were observed.	The interventions did not make a sustained improvement. The significance of the change was not tested.	**Low** The same recommendation applies to the EQR 2022.
9. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to the EQR 2022.
8. When analyzing multiple data points over time, Home State Health should consider tools such as time series, run charts, control charts, data dashboards, and basic trend analyses.	Line graphs showed trends of the primary measures in both PIPs and for some interventions.	**Medium** The same recommendation applies to EQR 2022.
EQR 2019		
1. Home State Health should follow CMS EQR protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015, for guidance	There was no improvement in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.

Previous Recommendation	Action by Home State Health	Home State Health's Degree of Response and EQRO's Recommendation
on the methodology and approach of PIPs to obtain meaningful results.		
2. Home State Health must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was some improvement in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.
3. The interventions should be planned specifically for the PIP required by the MHD contract.	The interventions were ongoing even when no improvement was evident for the last three years.	**Low** The same recommendation applies to EQR 2022.
4. The results should be tied to the interventions.	There was no improvement in the methodology of PIP in the EQR 2022.	**Low** The same recommendation applies to EQR 2022.

2.3 Findings, Analysis, and Conclusions: Healthy Blue

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description by Healthy Blue

This section briefly describes the PIP design, intervention(s), and results submitted by Healthy Blue.

Intervention. Healthy Blue offered a $ 10 reward through a new Healthy Rewards Member Incentive Program for all eligible members for the HEDIS CIS Combo 10 measure. To earn rewards for the Healthy Rewards Member Incentive Program, members must enroll in the program prior to or within 30 days of the service by calling Healthy Rewards Member Incentive Program or visiting the website hub. The reward dollars were loaded into the member's Healthy Rewards account after claims for influenza vaccination were received. Rewards could be redeemed for gift cards to various retailers, including Amazon, Kohl's, Subway, and Uber. Care managers educated the members on the Healthy Rewards Member Incentive Program. The information was also posted on the Healthy Blue website.

Performance Measure. Healthy Blue utilized the HEDIS CIS Combo 10 measure to

track the quarterly performance of the PIP. The measure was defined per the HEDIS technical specifications for MY 2021 as follows:
Numerator: The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three Haemophilus influenza type B (HiB); three hepatitis B (HepB), one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday
Denominator: All children, 2 years of age in the measurement year, who had continuous enrollment for at least 12 months prior to the child's second birthday and no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.

Variable. Healthy Blue measured the number of members eligible for the CIS Measure (2 years of age in MY 2021) who were non-compliant with the influenza vaccination as of August 2021 and, in turn, were awarded the Member Incentives for receiving the annual influenza vaccination. Healthy Blue named it as "participation rate" and defined it as follows:
Numerator: Eligible members, 2 years of age in MY 2021, who were awarded Healthy Rewards Member Incentives for receiving an influenza vaccination during the 2021 flu season (Aug 16-Dec 31, 2021).
Denominator: Children 2 years of age in MY 2021 who had continuous enrollment for at least 12 months prior to the child's second birthday and no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday who was non-compliant (had not received) the influenza vaccination as of August 2021.

Data Collection. To measure and track the project's performance, Healthy Blue monitored the HEDIS CIS Combo 10 rate quarterly and annually using administrative data (claims and encounter data). However, the final HEDIS CIS Combo-10 rate included administrative and hybrid data from medical record review (MRR). The claims data for the study were queried from the claims-based software and put into NCQA-certified software (Inovalon). Inovalon follows the HEDIS technical specifications to calculate the HEDIS CIS Combo 10 rate. Primary Care Providers and other health agencies submit claims and encounter data to the Vaccines for Children (VFC) Program, and Healthy Blue receives that information through the State immunization registry. This supplemental data and information obtained from Electronic Medical Records were used to identify vaccinations included in the CIS Combo-10 rate.
The participation rates of members who received the annual influenza vaccination as of August 2021 and received the newly launched rewards through the Healthy Rewards Member Incentive Program were tracked monthly from Aug 16-Dec 31, 2021. The

participation rates were calculated using HEDIS technical specifications, claims and encounter data, and the Healthy Rewards Member Incentive Program data.

Findings. Total non-complaint members (2 years of age) for influenza vaccines in Aug 2021 were 8,993. Table 2-8 shows the results of the intervention from Aug-Dec 2021.

Table 2-8. Healthy Rewards Member Incentive Program: Aug-Dec 2021

	Aug	Sept	Oct	Nov	Dec	Total
Number of members receiving influenza rewards.	0	4	54	60	70	187
Participation rate of receiving influenza rewards	0%	0.04%	0.6%	0.67%	0.78%	2.08%
95% Confidence Interval	N/A	0.01%-0.01%	0-0.09%	0.44%-0.77%	0.49%-0.84%	0-0.09%
Statistically Significant Improvement (Yes/No)	N/A	Yes	Yes	No	No	Yes

Table 2-9. Statewide HEDIS CIS Combo 10 Rates (MY 2020-2021)

Quarterly Measurements	Numerator	Denominator	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	95% Confidence Interval	Statistical Significance between Measurement Periods
Quarter 1	1030	5001	20.60%	14.15%	19.47% - 21.73%	Yes-Decline
Quarter 2	1161	4956	23.43%	16.11%	22.24% - 24.62%	Yes-Decline
Quarter 3	1209	4916	24.59%	17.27%	23.38% - 25.81%	Yes-Decline
Quarter 4	1203	4865	24.73%	17.68%	23.51% - 25.95%	Yes-Decline
Final Rate	148	411	36.01%	30.41%	31.25% - 40.77%	Yes-Decline

PIP Result

Healthy Blue did not meet the aim to increase the HEDIS CIS Combo 10 rate by 2% points from the previous year. The HEDIS CIS Combo 10 rate decreased from 36.01% (MY 2020) to 30.41% (MY 2021) by 5.6% points (Table 2-9). This decline was statistically significant.

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description by Healthy Blue

This section briefly describes the PIP design, intervention(s), and results submitted by Healthy Blue.

Intervention. In MY 2021, Healthy Blue partnered with mPulse to develop a robust

texting campaign reminding members to receive annual dental services. Additional educational information was included in the messages, as well as Healthy Blue's member services phone number to answer questions, help members find a dentist, or schedule transportation services to assist members in getting to their appointment. Members had the option to respond as "stop" or "wrong" to the text messages to disenroll from the texting campaign. If members have received services, texting "done" also disenrolled them. Texting "learn" provided additional oral health facts for educational information.
mPulse sends out text messages every two weeks until members receive dental care, disenroll, or until the campaign is completed. Up to six dental care messages are sent. If more than one member with the same phone number, such as siblings, only one message was sent per unique phone number. To be enrolled in the campaign, eligible members must have a care gap as of May 2021, must meet the criteria for the HEDIS ADV measure, and have a valid cell phone number with Healthy Blue. The text messages were in English and Spanish. The first text message was a welcome message indicating the communication was from Healthy Blue and allowed members the opportunity to opt-out. The first ADV-specific text was then sent. Members who received the ADV-specific text were considered in this PIP.

Performance Measure. Healthy Blue utilized the HEDIS ADV measure to track the performance of the PIP. The measure was defined per the HEDIS technical specifications for MY 2021 as follows:
Numerator: Eligible members, 2-20 years of age in MY 2021, identified as having one or more dental visits with a dental practitioner during the measurement year.
Denominator: Eligible members, 2-20 years of age in MY 2021, who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days.

Variable. A number of members, 2-20 years of age in MY 2021, who received the first HEDIS ADV specific text message between May 21-Dec 31, 2021, and the number of those members who obtained dental care in MY 2021 after getting the HEDIS ADV text message.

Data Collection. Claims and encounter data for the entire eligible population for the HEDIS ADV measure from the MY 2021 were queried from claims-based software and put into NCQA-certified software (Inovalon). Inovalon followed HEDIS technical specifications to calculate the HEDIS ADV rate. Additional data collected were based on the same HEDIS technical specifications for the ADV measure but focused on members who were enrolled in the mPulse texting campaign. HEDIS ADV rates were then compared to the prior year's monthly rates to assess the impact of the ADV text messages. The HEDIS ADV rate is calculated using administrative data only. MRR was not conducted for rate calculations.

Data sent from mPulse, identifying all members who received the first HEDIS ADV-specific text message, was then compared against claims data. Those members who received dental services after receiving the text were tracked monthly from May 21-Dec 31, 2021, for comparison and trending. HEDIS ADV rates were monitored monthly while the texting campaign was active and in April 2021 to serve as a baseline rate. HEDIS ADV rates were also tracked quarterly and annually to evaluate the impact of this intervention. Healthy Blue reviewed quarterly and annual HEDIS ADV rates to measure improvement over the prior year.

Findings. Healthy Blue analyzed that out of the total 117,841 members who received the first HEDIS ADV-specific text messages from May 21-Dec 31, 32,529 members subsequently visited the dentist (27.6%) (Table 2-10).

Table 2-10. mPulse Campaign Results: May-Dec 2021

	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
Number of members receiving dental care after ADV-specific text	308	5,629	5,292	5,156	4,286	4,137	4,455	3,266	32,529
Number of initial ADV-specific text messages	64,966	42,870	8,277	562	549	44	463	110	117,841

Healthy Blue evaluated rates to determine the length of time between the initial ADV-specific text and the dental visit. Healthy Blue reported that the text intervention was most impactful within the first 50 days of the initial ADV text (Figure 2-9). Members continued to receive texts biweekly until members disenrolled, received services, or the campaign ended. The texts were least impactful 201-225 days after the initial text.

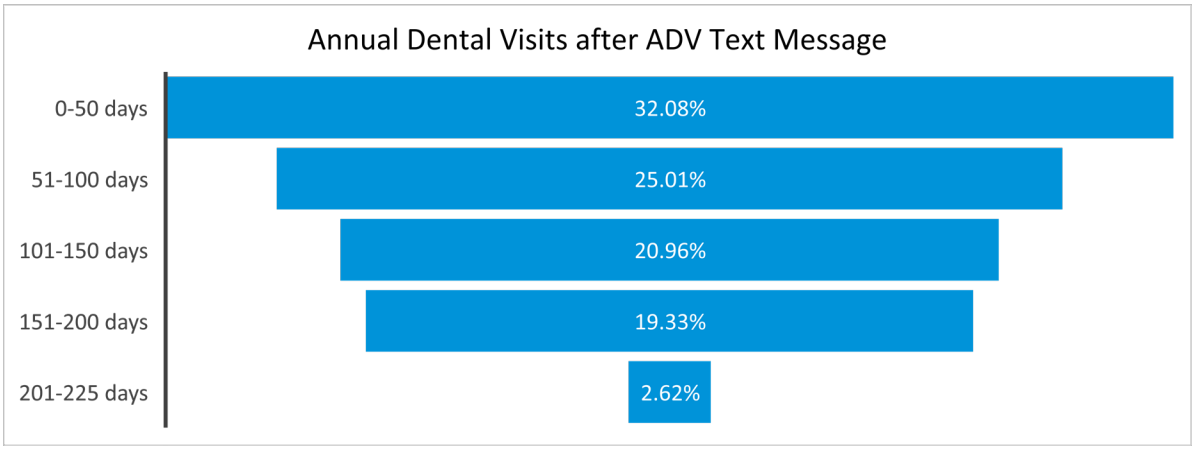


Figure 2-9. Response after ADV-Specific Text Message

Figure 2-10 and Table 2-11 show HEDIS ADV rates for the MY 2020 and MY 2021 tracked monthly and quarterly.

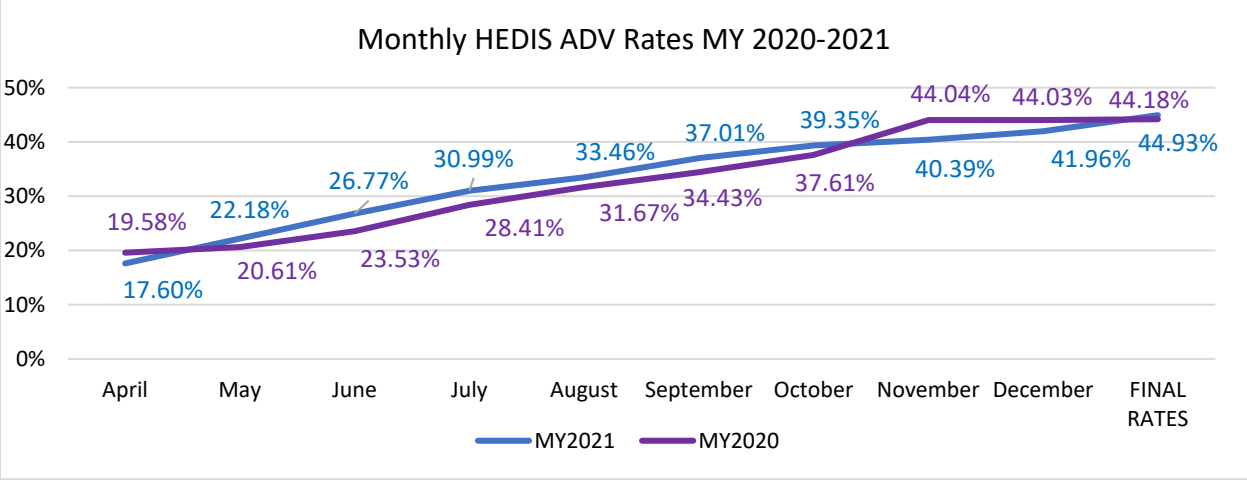


Figure 2-10. Monthly HEDIS ADV Rate: MY 2020-MY 2021

Table 2-11. Statewide HEDIS ADV Rates (MY 2020-2021)

Quarterly Measurements	HEDIS MY 2020	HEDIS MY 2021	95% Confidence Interval	Statistical Significance
Quarter 1	13.46%	15.34%	13.29% - 13.63%	Statistically Significant Improvement
Quarter 2	23.53%	26.77%	23.32% - 23.74%	Statistically Significant Improvement
Quarter 3	34.43%	37.01%	34.18% - 34.67%	Statistically Significant Improvement
Quarter 4	42.67%	41.96%	42.42% - 42.93%	Statistically Equivalent
Final HEDIS Rate	44.18%	44.93%	43.92% - 44.43%	Statistically Significant Improvement

PIP Result

Healthy Blue did not meet the aim to increase the HEDIS ADV rate by 2% points from the previous year. However, Healthy Blue reported an increase in the HEDIS ADV rate from 44.18% (MY 2020) to 44.93% (MY 2021) by 0.75% points. This change is statistically significant based on the 95% confidence limits (43.92%-44.43%).

2.3.1 Quality, Timeliness, and Access

PIPs Score. Healthy Blue did not meet the MHD's goal to increase the HEDIS CIS Combo 10 and HEDIS ADV rates by 2% points from the previous year. Also, the PIP methodology was not sound, so PTM assigned a score of "no confidence" for both clinical and nonclinical PIPs.

The PIPs did not meet all the required guidelines stated in the 42 CFR 438.330(d)(2)/MHD contract, section 2.18.8(d)(1) (Table 2-12).

Table 2-12. PIPs' Evaluation based on the CFR/MHD Guidelines

CFR Guidelines	CIS PIP	ADV PIP
Measurement of performance using objective quality indicators	Fully Met	Fully Met
Implementation of system interventions to achieve improvement in the access to and quality of care	Not Met	Not Met
Evaluation of the effectiveness of the interventions	Not Met	Not Met
Planning and initiation of activities for increasing or sustaining improvement.	Fully Met	Not Met

Strengths and Weaknesses. PTM identified the following strengths and weaknesses in the validation process of both the PIPs, summarized in Table 2-13.

Table 2-13. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic	N/A (the MHD provided the topic, hence marked as Not/Applicable-N/A)	N/A
2. Writing an Aim statement		The clinical PIP did not have a concise Aim statement, did not clearly specify the improvement strategy and the PIP population, nor identified a measurable or answerable target.
3. Identifying the study population	Healthy Blue had clarity on what constitutes the target population and the project population.	
4. Sampling		PTM determined that a non-probability sampling methodology (Judgmental/purposive) was utilized for both the clinical and nonclinical PIPs. However, Healthy Blue did not identify or report it.
5. Variables/performance measures (the MHD decided the primary measure)	The PIP variable and the performance indicator were selected and accurately defined.	Changes in enrollee satisfaction or experiences were not captured.
6. Data collection procedures	NCQA-certified software (Inovalon) was used to	Qualitative data collection methods were not used

Evaluation Criteria	Strength	Weakness
	collect data for the PIPs. The data sources were specified. The data collection plan and analysis plan were linked in the clinical PIP.	(such as interviews or focus groups) to collect meaningful and useful information from respondents. However, the nonclinical PIP had the option to receive members' responses.
7. Data analysis and interpretation of results		The baseline data for MY 2020 corresponding to parameters reported in MY 2021 for the intervention were not included. The data presented does not link to the intervention. PTM comments: Clinical PIP-The participation rate of members eligible for the HEDIS CIS Combo 10 who were non-compliant as of Aug 2021 and received incentives was 2.08%. The participation rate could be due to reminders, education, provider incentives, or other operational activities Healthy Blue applied. PTM comments: Nonclinical PIP-The data submitted by Healthy Blue revealed that the dental visits exceeded the texts in Aug (917%), Sept (780%), Oct (9402%), Nov (962%), Dec (2969%), showing no link to the intervention and results.
8. Improvement strategies	The selected strategies for both the PIPs were evidence-based and were identified through data analysis and a quality improvement process.	The usefulness of the improvement strategies was not based on the PDSA cycle, even though Healthy Blue reportedly used PDSA. The intervention was ongoing,

Evaluation Criteria	Strength	Weakness
		and results were reported monthly.
9. Significant and sustained improvement		The overall HEDIS CIS Combo 10 rate significantly decreased from 36.01% (MY 2020) to 30.41% (MY 2021). The success of the intervention showed a participation rate of 2.08%. The overall HEDIS ADV rate showed an improvement of 0.75% points in the MY 2021, which was reported as statistically significant. However, Healthy Blue reported that the annual dental visits every 50 days showed a continuous drop from 32.08% to 2.62% by the end of the intervention (May-Dec 2021).

2.3.2 Improvement from previous year

Table 2-14 shows the degree to which Healthy Blue responded to EQRO's recommendations from the previous years' EQRs and PTM's new recommendations applicable in the current EQR 2022. (Refer to Table 2-13 for Healthy Blue's performance in EQR 2022.)

Table 2-14. Degree of response to EQRO's previous recommendations

Previous Recommendation	Action by Healthy Blue	Healthy Blue's Degree of Response and EQRO's Recommendation
EQR 2021		
1. Aim Statement: Healthy Blue must have one aim statement for their PIP, which can have multiple objectives (if they choose). The PIP aim statement should be concise and define the improvement strategy, population, and period.	Healthy Blue followed the recommendation regarding one Aim statement. However, the Aim statement for the clinical PIP was not accurately defined.	**Medium** The same recommendation applies to the EQR 2022.

Previous Recommendation	Action by Healthy Blue	Healthy Blue's Degree of Response and EQRO's Recommendation
2. Study Population: Healthy Blue should articulate the concepts and clearly define the target population and PIP population. The PIP population should be selected at a small scale (e.g., from a county, provider office, or region) so that results can be measured during the PDSA cycle and subsequently applied at a larger scale.	Healthy Blue met the requirements for both PIPs.	**High**
3. PDSA Cycles: Healthy Blue must adopt PDSA cycles that involve analysis, feedback/lessons learned from the data collected after the intervention, and application of these outcomes to plan another test cycle.	Though Healthy Blue reported using the PDSA cycles for both the PIPs, PTM determined that the process was not followed.	**Low** The same recommendation applies to the EQR 2022.
4. Data Analysis and Interpretation of Results: Though conclusive demonstration through controlled studies is not required, Healthy Blue should compare the results across multiple entities, such as different patient subgroups and provider sites, to ascertain the change brought by the intervention.	Healthy Blue did not meet the requirements.	**Low** The same recommendation applies to the EQR 2022.
5. Sustained improvement: After an intervention is implemented and results are analyzed, Healthy Blue should identify strategies to create a sustained improvement. This allows Healthy Blue to maintain the positive results of the intervention, correct negative results, and scale the intervention to support longer-term improvements or broader improvement capacity across other health services, populations, and aspects of care. Because PIPs can be	Healthy Blue did not meet the requirements for both PIPs. The interventions were ongoing without demonstrating improvement.	**Low** The same recommendation applies to the EQR 2022. In addition, a target should be set for the intervention based on the goal of the PIP. The intervention should be adopted, adapted, or abandoned with each

Previous Recommendation	Action by Healthy Blue	Healthy Blue's Degree of Response and EQRO's Recommendation
resource-intensive, this phase also helps learn how to allocate more efficiently for future projects.		PDSA cycle based on the results obtained.
EQR 2020		
1. Even though the MHD mandates an overarching goal, Healthy Blue can select a topic within specified parameters. To ensure a successful PIP, Healthy Blue should find early and regular opportunities to obtain input from staff, providers, and members, improving care delivery.	There was some improvement towards this step in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022.
2. Healthy Blue should translate the Aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle). PIP population should be selected from a county, provider office, or region so that results can be measured during the PDSA cycle and subsequently applied on a larger scale.	There was some improvement towards this step in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022.
3. Healthy Blue should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify Healthy Blue's performance on the PIPs and track improvement over time. Healthy Blue can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary measures or supplement the overall	There was an improvement towards this step in the methodology of PIP in EQR 2022 compared to EQR 2021. Variables were selected.	**Medium** Healthy Blue should include qualitative measures to link the intervention to the improvement.

Previous Recommendation	Action by Healthy Blue	Healthy Blue's Degree of Response and EQRO's Recommendation
measurement set, providing information that will aid PIP planning and implementation.		
4. Healthy Blue should use variables/secondary measures that tie an intervention to improvement. Clear and concise definitions of data elements (including numerical definitions and units of measure) should be provided for the data collected after the intervention.	There was an improvement in the EQR 2022. The variables were selected, and the data elements were defined accurately.	**High**
5. Data collection plan should be linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	There was an improvement in the EQR 2022.	**High**
6. A baseline rate should be presented before the start of an intervention, followed by at least two remeasurements. Analysis of results should be utilized to plan the subsequent intervention (cycle-PDSA) for future PIP. Additionally, primary and secondary measures/variables should be linked to illustrate the impact of the intervention on a project's performance.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.
7. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.
8. When analyzing multiple data points over time, Healthy Blue should consider tools such as time	There was some improvement in the EQR 2022.	**Medium**

Previous Recommendation	Action by Healthy Blue	Healthy Blue's Degree of Response and EQRO's Recommendation
series, run charts, control charts, data dashboards, and basic trend analyses.		The same recommendation applies to EQR 2022.
EQR 2019		
1. Health Blue should follow CMS EQR protocol and Medicaid Oral Health Performance Improvement Projects: A How-To Manual for Health Plans, July 2015, for guidance on the methodology and approach of PIPs to obtain meaningful results.	There was some improvement in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022.
2. Healthy Blue must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was some improvement in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022.
3. The interventions should be planned specifically for the PIP required by the MHD contract.	There was some improvement in EQR 2022. However, the interventions were ongoing even when no improvement was evident.	**Medium** The same recommendation applies to EQR 2022.
4. The results should be tied to the interventions.	There was no improvement in the methodology of PIP in the EQR 2022.	**Low** The same recommendation applies to EQR 2022.

2.4 Findings, Analysis, and Conclusions: UnitedHealthcare

(A) Clinical PIP: Improving Childhood Immunization Status

PIP Description by UnitedHealthcare

This section of the report briefly describes the PIP design, intervention(s), and results submitted by UnitedHealthcare.

Intervention. UnitedHealthcare selected the TTEC Live Agent Program as its intervention for MY 2021. The intervention was launched on Oct 6, 2021. TTEC is the name of the vendor who provided targeted live outreach calls to 822 members who were non-compliant with the HEDIS CIS Combo 10 measure in Clay County, Jackson County, Jefferson County, St. Charles County, St. Louis County, and St. Louis City. The program consisted of live agents making outbound calls to noncompliant members and assisting the members with scheduling appointments to close the gap(s). The three types of calls were included in the program:

- Initial Call: If a member answers and authenticates, the agent then assists the member in making an appointment if they do not have one.
- Reminder Call: Based on the date of the scheduled appointment, a call was made prior to the appointment.
- Follow-up Call: A call was also made to ensure the member attended the appointment. If the member did not go, the agent attempted to reschedule the appointment with the member.

The outgoing call from TTEC showed United Healthcare on the caller ID if this feature was available on the member's phone. Once connected with a member, assistance to schedule the appointment was offered. If accepted, a three-way call was made to the member's primary care provider to schedule the immunization appointment. Members were able to return calls to TTEC when voicemails were left.

Performance Measure. UnitedHealthcare utilized HEDIS CIS Combo 10 as the primary measure and HEDIS CIS Combo 10 in 6 counties targeted in the PIP as the secondary measure. The measures were defined per the NCQA HEDIS technical specifications.

Variable. The variable used in the development of this PIP focused on members who turned two years old in MY 2021 and who were non-compliant with the CIS Combo 10 HEDIS measure.

Data Collection. UnitedHealthcare used Inovalon, a HEDIS-certified software engine, to generate the HEDIS CIS Combo 10 measure to ensure a systematic method for collecting valid and reliable data representing the population. The primary measure was reported and analyzed monthly along with the annual rate statewide/region-wise. The secondary measure results were monitored monthly for the six counties included in the intervention. In addition, the data after the intervention was monitored monthly. The data available to review were as follows:

- Call disposition/reach rate/appointment detail (i.e., call back request, hang-up, left a message, scheduled an appointment).
- Reasons for appointment not being scheduled after authentication.

- At the end of the measurement period, research immunization claims for members included in the intervention to identify a correlation between calls and immunization visits.

Findings. UnitedHealthcare summarized the intervention outcomes in Tables 2-15 and 2-16.

Table 2-15. TTEC Live Agent Program Outcomes CIS PIP

Disposition	October	November	December	Totals
Busy	2 (.91%)	2 (1.23%)	27 (1.63%)	31
Call Back Requested	3 (1.36%)	0 (0.00%)	5 (.30%)	8
Do Not Call (remove from list)	3 (1.36%)	0 (0.00%)	7 (.42%)	10
Failed Authentication	15 (6.82%)	1 (0.62%)	7 (.42%)	23
Fax machine	0 (0.00%)	0 (0.00%)	0 (0.00%)	0
Hang Up	15 (6.82%)	4 (2.47%)	98 (5.91%)	117
Left Message	100 (45.45%)	90 (55.56%)	1009 (60.82%)	1199
Left message with different person	4 (1.82%)	1 (.62%)	17 (1.02%)	22
No answer	34 (15.45%)	27 (16.67%)	262 (15.79%)	323
No longer a member	0 (0.00%)	2 (1.23%)	9 (.54%)	11
Number disconnected	15 (6.82%)	14 (8.64%)	66 (3.98%)	95
Authenticated-Appointment already scheduled	16 (7.27%)	12 (7.41%)	70 (4.22%)	98
Authenticated-No appointments made	3 (1.36%)	2 (1.23%)	26 (1.57%)	31
Authenticated-Appointment Scheduled	3 (1.36%)	2 (1.23%)	17 (1.02%)	22
Unauthenticated	4 (1.82%)	2 (1.23%)	10 (.60%)	16
Wrong number	3 (1.36%)	3 (1.82%)	29 (1.75%)	35
Total	220	162	1659	2041

Table 2-16. Member Outcomes: TTEC Intervention CIS PIP

Member Outcomes*	Total
Number of members outreached	822
Number of members authenticated	151 (18.4%)
Number of members' appointments already scheduled	98 (11.9%)
Number of members' appointments scheduled on call	22 (2.7%)
Number of members who did not schedule appointments	31 (3.8%)

*De-duplicated members and counts. Final call disposition for each member at the end of the intervention timeline (12/31/2021).

UnitedHealthcare summarized its findings from the intervention as follows:

- 150 members were authenticated:
  - Of the 97 members who said they had already scheduled an appointment, 14 had an immunization claim between October 8 -December 31, 2021.
  - Of the 31 members who authenticated and did not schedule an appointment while on the call, 4 had an immunization claim between October 8 -December 31, 2021.
  - Of the 22 members who were authenticated and scheduled an appointment while on the call, 9 had an immunization claim between October 8 -December 31, 2021.
  - A total of 27 members who were authenticated had an immunization claim between October 8 -December 31, 2021.
- 671 members did not answer/were not authenticated: 83 had an immunization claim between October 8 -December 31, 2021

(PTM determined the intervention success rate was 0.01%-9 received immunization of 822 members who were called. There are minor discrepancies in the numbers in Table 2-16 and the summarized findings).

Table 2-17 presents the HEDIS CIS Combo 10 rates in the six targeted counties during the time of intervention, along with the statistical significance, and Table 2-18 shows rates for individual counties.

Table 2-17. HEDIS CIS Combo 10 Rate in Six Counties: Oct-Dec 2021 (Admin Data)

Measurement Period	Measurement	Numerator	Denominator	Rate	Benchmark (50th percentile)	Goal (2%)
Oct 2021 (claims as of 10/7/21)	Baseline	463	3631	12.75%	38.20%	38.25%
Nov 2021 (claims as of 11/7/21)	Remeasurement 1	415	3260	12.73%	38.20%	38.25%
Dec 2021 (claims as of 12/7/21)	Remeasurement 2	437	3351	13.04%	38.20%	38.25%
2021 Runout (claims as of 12/31/2021)	Remeasurement 3	459	3528	13.01%	38.20%	38.25%

Statistically Significant? (Yes/No)	Pearson's Chi Sq	p-value	Measure Periods Compared
No	.0007	.9789	Baseline to RM1
No	.1422	.7061	RM1 to RM 2
No	.0049	.9441	RM2 to RM3
No	.1906	.6624	Baseline to RM3

Table 2-18. HEDIS CIS Combo 10 Rate in Individual Six Counties

Baseline Oct 2021	Clay County	Jackson County	Jefferson County	St. Charles County	St. Louis County	St. Louis City	Total
Numerator	52	174	29	31	140	37	**463**
Denominator	261	1178	184	278	1187	543	**3631**
Rate	19.92%	14.77%	15.76%	11.15%	11.79%	6.81%	**12.75%**
Remeasurement 1 Nov 2021	Clay County	Jackson County	Jefferson County	St. Charles County	St. Louis County	St. Louis City	Total
Numerator	48	152	30	29	127	29	**415**
Denominator	245	1072	166	257	1100	420	**3260**
Rate	19.59%	14.18%	18.07%	11.28%	11.55%	6.90%	**12.73%**
Remeasurement 2 Dec 2021	Clay County	Jackson County	Jefferson County	St. Charles County	St. Louis County	St. Louis City	Total
Numerator	50	163	30	29	135	30	**437**
Denominator	253	1111	170	263	1124	430	**3351**
Rate	19.76%	14.67%	17.65%	11.03%	12.01%	6.98%	**13.04%**
Remeasurement 3 Retrospective Runout	Clay County	Jackson County	Jefferson County	St. Charles County	St. Louis County	St. Louis City	Total
Numerator	50	177	29	30	133	40	**459**
Denominator	249	1131	175	266	1164	543	**3528**
Rate	20.08%	15.65%	16.57%	11.28%	11.43%	7.37%	**13.01%**

Table 2-19 presents HEDIS CIS Combo 10 rates in the six counties (secondary measure) compared to the rates for the members turning 2 years old in the rest of the state.

Table 2-19. HEDIS CIS Combo 10 Rate: Six counties vs. All other MO counties

Baseline Oct 2021	Secondary Measure Counties	All Other Counties
Numerator	463	549
Denominator	3631	4732
Rate	12.75%	11.60%

Remeasurement 1 Nov 2021	Secondary Measure Counties	All Other Counties
Numerator	415	506
Denominator	3260	4350
Rate	12.73%	11.63%
Remeasurement 2 Dec 2021	Secondary Measure Counties	All Other Counties
Numerator	437	518
Denominator	3351	4445
Rate	13.04%	11.65%
Remeasurement 3 Retrospective Runout	Secondary Measure Counties	All Other Counties
Numerator	459	581
Denominator	3528	4938
Rate	13.01%	11.77%

Figure 2-11 shows the statewide HEDIS CIS Combo 10 rates for MY 2020 and before and after the intervention for MY 2021.

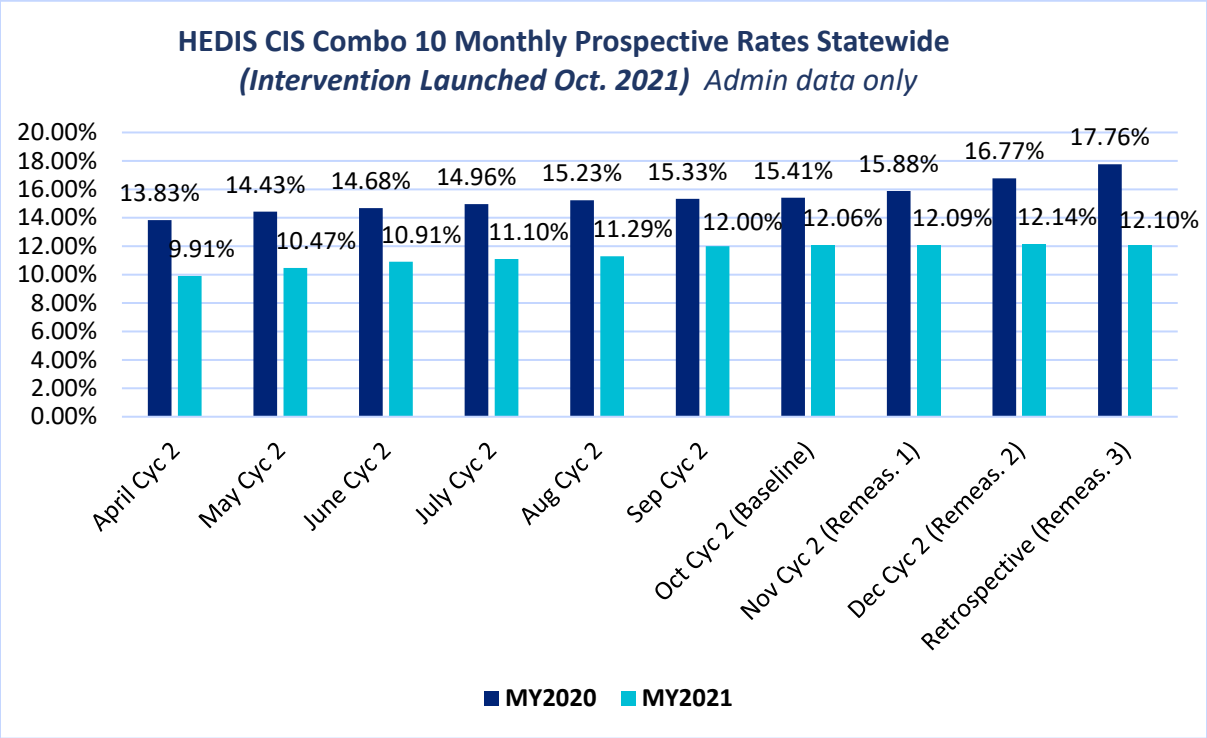


Figure 2-11. HEDIS CIS Combo 10 Rates MY 2020-2021

Table 2-20 presents primary measure data statewide for Oct-Dec 2021 for the intervention period and statistical significance.

Table 2-20. Statewide HEDIS CIS Combo 10 Rates: Oct-Dec 2021 (Admin Data)

Measurement Period	Measurement	Numerator	Denominator	Rate	Benchmark (50th pct)	Goal (2%)
Oct 2021 (claims as of 10/7/21)	Baseline	1014	8409	12.06%	38.20%	38.25%
Nov 2021 (claims as of 11/7/21)	Remeasurement 1	1014	8388	12.09%	38.20%	38.25%
Dec 2021 (claims as of 12/7/21)	Remeasurement 2	1016	8370	12.14%	38.20%	38.25%
2021 Runout (claims as of 12/31/2021)	Remeasurement 3	1026	8481	12.10%	38.20%	38.25%
Statistically Significant? (Yes/No)	**Pearson's Chi Sq**	**p-value**	**Measure Periods Compared**			
No	.0036	.9521	Baseline to RM1			
No	.0098	.9213	RM1 to RM 2			
No	.0430	.8357	RM2 to RM3			
No	.0061	.9378	Baseline to RM3			

Figure 2-12 illustrates the final (hybrid) CIS Combo 10 rates from MY 2018-MY 2021.

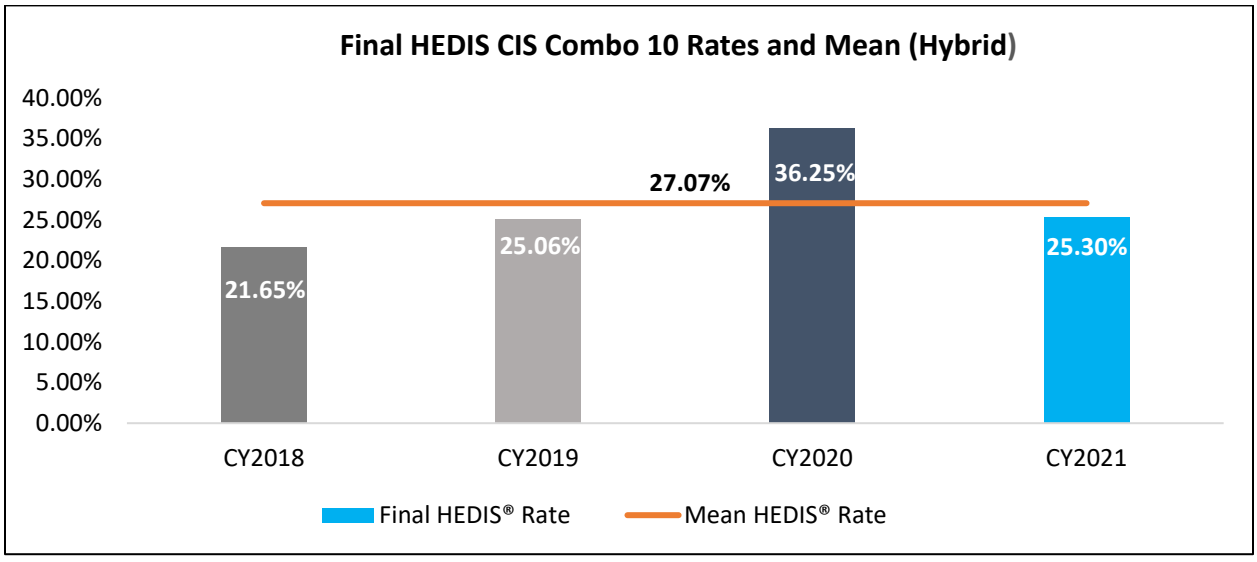


Figure 2-12. HEDIS CIS Combo 10 Trend (MY 2018-2021)

PIP Result

UnitedHealthcare did not meet the aim to increase the HEDIS CIS Combo 10 rate by 2% points from the previous year. The HEDIS CIS Combo 10 rate decreased from 36.25% (MY 2020) to 25.3% (MY 2021) by 10.95% points (Figure 2-12). This decline was statistically

significant. PTM summarized UnitedHealthcare's data for primary and secondary measures for comparison as follows (Table 2-21).

Table 2-21. Primary and Secondary Measures (Admin Data) MY 2020-2021

Measurement Period	HEDIS CIS Combo 10 Rate Six counties	HEDIS CIS Combo 10 Statewide
Oct (baseline) 2021	12.75%	12.06%
October to November 2021	12.73%	12.09%
November to December 2021	13.04%	12.14%
December to Retrospective 2021	13.01%	12.10%
Baseline-Final Rate MY 2020	21.54%	17.76%

(B) Nonclinical PIP: Improving Oral Healthcare

PIP Description by UnitedHealthcare

This section briefly describes the PIP design, intervention(s), and results submitted by UnitedHealthcare.

Intervention. TTEC Live Agent Calling Program: The program consisted of live agents making outbound calls to members non-compliant with specific HEDIS measures and assisted the members with scheduling appointments to close the gap(s). Three types of calls were included in the program:

- Initial Call: If a member answers and authenticates, the agent then assists the member in making an appointment if they do not have one.
- Reminder Call: Based on the date of the scheduled appointment, a call will be made prior to the appointment.
- Follow-Up Call: A call will also be made to ensure the member attended the appointment. If the member did not go, the agent attempted to reschedule the appointment with the member.

A list of 4,768 members aged 4-6 years located in Jackson County, Saint Louis County, and Saint Louis City who were non-compliant for ADV was provided to the vendor for outreach. A total of 4,177 members were outreached.

Performance Measure. The Primary Measure used to measure the outcome of the PIP was the HEDIS ADV measure, which measures the number of members aged 2-20 years who had at least one dental visit during the measurement year. The secondary measure utilized available HEDIS member-level detail (MLD) data to monitor ADV compliance for members aged 4-6 years in the specific counties of Jackson County, Saint Louis County, and

Saint Louis City throughout the PIP intervention process.

Variable. The eligible members who had not received a dental visit in MY 2021.

Data Collection. UnitedHealthcare used Inovalon, a HEDIS-certified software engine, to generate the annual HEDIS ADV measure final rate. Data incorporated into Inovalon for the ADV measure was based on dental claims/encounters. The HEDIS ADV measure was analyzed and interpreted monthly using prospective data. For the Secondary Measure, Inovalon generated unaudited prospective data monthly throughout the measurement year. UnitedHealthcare's Quality team used the ADV MLD data to extract the rates for members aged 4-6 years who lived in Jackson County, Saint Louis County, and Saint Louis City prior to the TTEC Live Agent Calling Program and monthly after that. Call results were generated monthly to evaluate the effectiveness of the intervention. Data available to review were as follows:

- Call disposition/reach rate/appointment detail (i.e., call back request, hang-up, left a message, scheduled an appointment).
- Covid-19 barrier report (tracks any barriers to scheduling an appointment due to Covid-19).
- At the end of the measurement period, dental claims were researched for members included in the program to identify a correlation between calls and dental visits.

Findings. The intervention outcomes are summarized in Tables 2-22 and 2-23.

Table 2-22. TTEC Live Agent Program Outcomes ADV PIP

Call Disposition	October	November	December	Total
Busy	7 (0.53%)	9 (1.09%)	142 (1.76%)	158 (1.55%)
Call Back Requested	19 (1.43%)	3 (0.36%)	42 (0.52%)	64 (0.63%)
Do Not Call (remove from list)	7 (0.53%)	2 (0.24%)	14 (0.17%)	23 (0.23%)
Failed Authentication	14 (1.06%)	3 (0.36%)	2 (0.02%)	19 (0.19%)
Fax machine	1 (0.08%)	1 (0.12%)	-	2 (0.02%)
Hang Up	59 (4.45%)	41 (4.95%)	447 (5.55%)	547 (5.36%)
Left Message	644 (48.60%)	423 (51.09%)	4454 (55.28%)	5521 (54.07%)
Left message with different person	10 (0.75%)	4 (0.48%)	72 (0.89%)	86 (0.84%)
No answer	278 (20.98%)	192 (23.19%)	1668 (20.70%)	2138 (20.94%)

No longer a member	5 (0.38%)	9 (1.09%)	23 (0.29%)	37 (0.36%)
Number disconnected	107 (8.08%)	58 (7.00%)	425 (5.27%)	590 (5.78%)
Authenticated-Appointment already scheduled	37 (2.79%)	20 (2.42%)	197 (2.45%)	254 (2.49%)
Authenticated-No appointments made	49 (3.70%)	11 (1.33%)	200 (2.48%)	260 (2.55%)
Authenticated-Appointment Scheduled	18 (1.36%)	14 (1.69%)	95 (1.18%)	127 (1.24%)
Unauthenticated	25 (1.89%)	11 (1.33%)	94 (1.17%)	130 (1.27%)
Wrong number	45 (3.40%)	27 (3.26%)	182 (2.26%)	254 (2.49%)
Total	1325	828	8057	10,210

Table 2-23. Member Outcomes: TTEC Intervention ADV PIP

Member Outcomes*	Total
Number of members outreached	4,177
Number of members authenticated	638 (15.3%)
Number of members' appointments already scheduled	253 (6.1%)
Number of members' appointments scheduled on call	127 (3.0%)
Number of members who did not schedule appointments	259 (6.2%)

*De-duplicated members and counts. Final call disposition for each member at the end of the intervention timeline (12/31/2021).

UnitedHealthcare summarized its findings from the intervention as follows:

- 638 members were authenticated:
  - Of the 253 members who said they had already scheduled an appointment, 121 had a dental claim in 2021.
  - Of the 259 members who did not schedule an appointment while on the call, 26 had a dental claim in 2021.
  - Of the 127 members who scheduled an appointment while on the call, 26 had a dental claim in 2021.
  - A total of 173 members (27%) who were authenticated had a dental visit in MY 2021.
- Of the 3,539 members who did not answer/were not authenticated, 554 (16%) had a dental visit in 2021.

(PTM determined the intervention success rate was 0.62%-26 had dental visits of 4177 members who were called).

Table 2-24 presents the HEDIS ADV rates in the three targeted counties during the time of intervention and their statistical significance, and Table 2-25 presents rates for individual counties. The HEDIS ADV rate for members 4-6 years in Jackson County, St. Louis County, and St. Louis City) increased from 40.48% (MY 2020) to 44.29% (MY 2021), an increase of 3.81% points but is not linked to the intervention.

Table 2-24. HEDIS ADV Rate in Three Counties: Oct-Dec 2021

Measurement Period	Measurement	Numerator	Denominator	Rate	Benchmark (50th pct)	Goal (2%)
October 2021 (claims as of 10/7/21)	Baseline	2666	7324	36.40%	50.59%	42.28 %
November 2021 (claims as of 11/7/21)	Remeasurement 1	2595	6592	39.37%	50.59%	42.28 %
December 2021 (claims as of 12/7/21)	Remeasurement 2	2813	6690	42.05%	50.59%	42.28 %
2021 Runout (claims as of 12/31/21)	Remeasurement 3	3078	6950	44.29%	50.59%	42.28 %
Statistically Significant? (Yes/No)	**Pearson's Chi Sq**	**p-value**	**Measure Periods Compared**			
Yes	12.9718	0.00031	Baseline to RM1			
Yes	9.8940	0.00166	RM1 to RM 2			
No	6.9705	0.00827	RM2 to RM3			
Yes	92.2418	0.00000	Baseline to RM3			

Table 2-25. HEDIS ADV Rate in Individual Three Counties

Baseline October 2021	Jackson	St. Louis	St. Louis City	Total
Numerator	1293	937	436	2666
Denominator	3171	2867	1286	7324
Rate	40.78%	32.68%	33.90%	36.40%
Remeasurement 1 November 2021	Jackson	St. Louis	St. Louis City	Total
Numerator	1248	944	403	2595
Denominator	2870	2610	1112	6592
Rate	43.48%	36.17%	36.24%	39.37%
Remeasurement 2 December 2021	Jackson	St. Louis	St. Louis City	Total
Numerator	1360	1023	430	2813
Denominator	2930	2642	1118	6690
Rate	46.42%	38.72%	38.46%	42.05%
Remeasurement 3 Retrospective Runout	Jackson	St. Louis	St. Louis City	Total
Numerator	1480	1101	497	3078
Denominator	3008	2717	1225	6950
Rate	49.20%	40.52%	40.57%	44.29%

Table 2-26 presents HEDIS ADV rates in the three counties (secondary measure) compared to the rates for the members in the rest of the state.

Table 2-26. HEDIS ADV Rate: Three Counties vs. All other MO Counties

Baseline October 2021	**Secondary Measure**	**ADV Members (4-6 years in all other MO counties)**
Numerator	2666	5797
Denominator	7324	14831
Rate	36.40%	39.09%
Remeasurement 1 November 2021	Secondary Measure	ADV Members (4-6 years in all other MO counties)
Numerator	2595	5749
Denominator	6592	13547
Rate	39.37%	42.44%
Remeasurement 2 December 2021	Secondary Measure	ADV Members (4-6 years in all other MO counties)
Numerator	2813	6217
Denominator	6690	13793
Rate	42.05%	45.07%
Remeasurement 3 Retrospective Runout	Secondary Measure	ADV Members (4-6 years in all other MO counties)
Numerator	3078	6696
Denominator	6950	14053
Rate	44.29%	47.65%

Figure 2-13 shows the statewide HEDIS ADV rates for MY 2020 and before and after the intervention in MY 2021.
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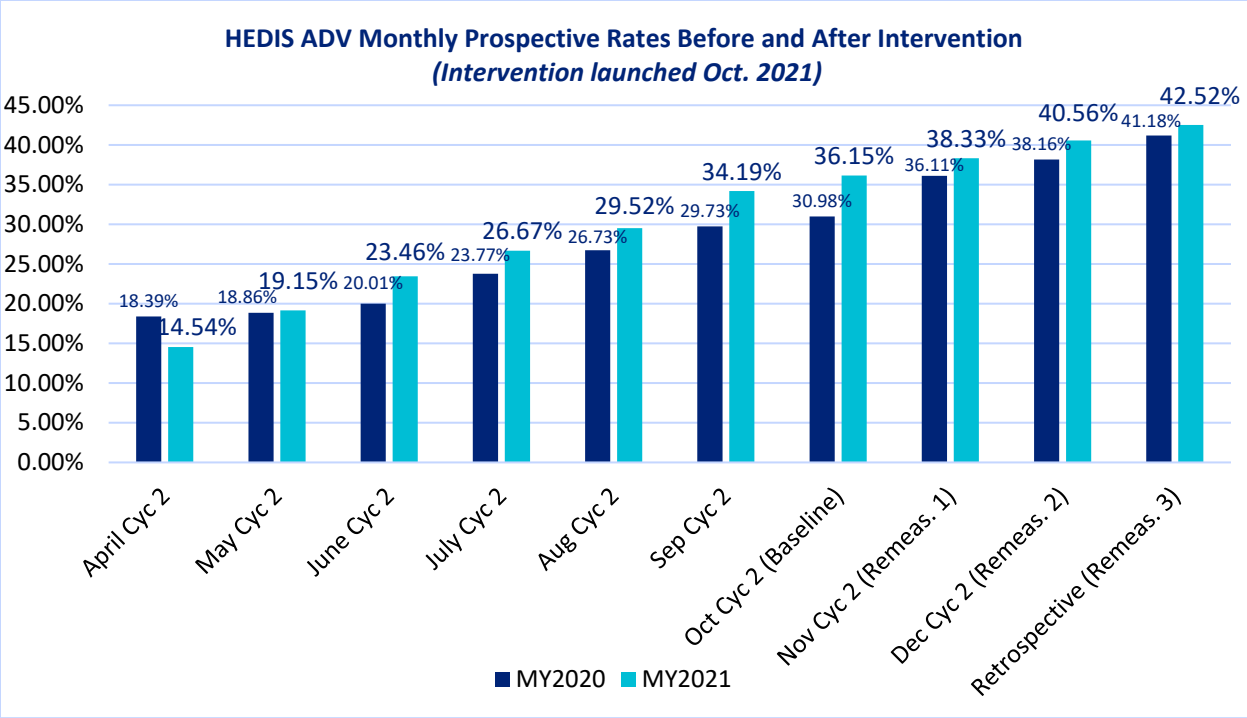

Figure 2-13. HEDIS ADV Rates MY 2020-2021

Table 2-27 presents primary measure data statewide for Oct-Dec 2021 for the intervention period and statistical significance.

Table 2-27. Statewide HEDIS ADV Rates: Oct-Dec 2021

Measurement Period	Measurement	Numerator	Denominator	Rate	Benchmark (50 th Pct)	Goal (2%)
October 2021 (claims as of 10/7/21)	Baseline	47,841	132,341	36.15%	45.77%	43.18%
November 2021 (claims as of 11/7/21)	Remeasurement 1	50,299	131,222	38.33%	45.77%	43.18%
December 2021 (claims as of 12/7/21)	Remeasurement 2	52,820	130,221	40.56%	45.77%	43.18%
2021 Runout (claims as of 12/31/21)	Remeasurement 3	54,762	128,798	42.52%	45.77%	43.18%
Statistically Significant-Yes/No	**Pearson's Chi Sq**	**p-value**	**Measure Periods Compared**			
Yes	134.1610	.00000	Baseline to RM1			
Yes	136.1502	.00000	RM1 to RM 2			
Yes	102.0130	.00000	RM2 to RM3			
Yes	1109.65	.00000	Baseline to RM3			

PIP Result

UnitedHealthcare did not meet the MHD's goal to increase the HEDIS ADV rate by 2% points from the previous year though the HEDIS ADV rate increased from 41.18% (MY 2020) to 42.39% (MY 2021) by 1.21% points which was statistically significant.

2.4.1 Quality, Timeliness, and Access

PIPs Score. UnitedHealthcare did not meet the aim to increase the HEDIS CIS Combo 10 and HEDIS ADV rates by 2% points from the previous year. Also, the PIP methodology was not sound, so PTM assigned a score of "no confidence" for both clinical and nonclinical PIPs. The PIPs did not meet all the required guidelines stated in the 42 CFR 438.330(d)(2)/MHD contract, section 2.18.8(d)(1) (Table 2-28).

Table 2-28. PIPs' Evaluation based on the CFR/MHD Guidelines

CFR Guidelines	CIS PIP	ADV PIP
Measurement of performance using objective quality indicators	Partially Met	Partially Met
Implementation of system interventions to achieve improvement in the access to and quality of care	Not Met	Not Met
Evaluation of the effectiveness of the interventions	Not Met	Not Met
Planning and initiation of activities for increasing or sustaining improvement.	Partially Met	Partially Met

Strengths and Weaknesses. PTM identified the following strengths and weaknesses in the validation process of both the PIPs, summarized in Table 2-29.

Table 2-29. Strengths and Weaknesses of PIPs

Evaluation Criteria	Strength	Weakness
1. Selection of PIP topic	N/A (the MHD provided the topic, hence marked as Not/Applicable-N/A)	UnitedHealthcare did not mention explicitly whether the PIP included special populations or high-priority services.
2. Writing an Aim statement	The PIP Aim statement was concise and defined the improvement strategy, population, and period.	
3. Identifying the study population		UnitedHealthcare lacks clarity on what constitutes the target population and

Evaluation Criteria	Strength	Weakness
		the project population.
4. Sampling		A non-probability sampling methodology (convenience type) was utilized for clinical and nonclinical PIPs. However, UnitedHealthcare did not correctly report that in the non-clinical PIP.
5. Variables/performance measures (the MHD decided the primary measure)	UnitedHealthcare's national Quality Solutions Delivery (QSD) team manages all HEDIS-related activities, including vendor training and State-specific reporting. There is an overread process for all HEDIS hybrid measures and final validation by an NCQA-certified auditor.	Even though UnitedHealthcare reported using variables in the PIPs, they were incorrectly defined. Changes in enrollee satisfaction or experiences were not captured.
6. Data collection procedures	The data collection plan and analysis plan were linked. Inovalon, a HEDIS-certified software engine, generated primary and secondary measure results. The TTEC program included reporting with call results, reach rate reports, and barrier reports.	Qualitative data collection methods were not used (such as interviews or focus groups) to collect meaningful and valuable information from respondents. UnitedHealthcare did not provide information regarding the data sources: if they used data for inpatients, primary care providers, specialty care providers, ancillary service providers, and if Electronic Health Records (EHR) were utilized.
7. Data analysis and interpretation of results	The analysis of the intervention and the primary measure included the baseline data and repeat measurements.	The secondary measure analysis did not include the baseline data (MY 2020) for the six counties (clinical PIP) and three counties (non-clinical PIP) for the corresponding period of intervention (Oct-Dec 2020).

Evaluation Criteria	Strength	Weakness
		Though the final MY 2020 baseline for the counties was reported, it was not included in the analysis. Also, the data corresponding to the noncompliant members who were the focus of the intervention was not provided for the MY 2020. The data presented does not link to the intervention. The PIP findings were not concise and were repetitive.
8. Improvement strategies	Both the PIPs utilized the same operational strategy in other states served by UnitedHealthcare. Barrier analysis and a care management survey were conducted to select the strategy.	The usefulness of the improvement strategies was not based on the PDSA cycle, even though UnitedHealthcare reportedly used PDSA. The intervention was ongoing, and results were reported monthly. The secondary measure rates were compared between the six counties (clinical PIP)/three counties (non-clinical PIP) included in the intervention and all other counties in MO collectively. However, PTM determined that this collective comparison does not give any meaningful input to the quality improvement process. PTM determined the success rate (no. of members outreached to the number of members received care due to the outreach per 100 members) of the intervention was 0.01% for clinical PIP and 0.62% for non-clinical PIP.

Evaluation Criteria	Strength	Weakness
9. Significant and sustained improvement		The overall HEDIS CIS Combo 10 rate significantly decreased from 36.25% (MY 2020) to 25.3% (MY 2021). The overall HEDIS ADV rate increased from 41.18% (MY 2020) to 42.39% (MY 2021), showing a statistically significant improvement of 1.21% points. However, improvement is unlikely due to the intervention.

2.4.2 Improvement from previous year

Table 2-30 shows the degree to which UnitedHealthcare responded to EQRO's recommendations from the previous years' EQRs and PTM's new recommendations applicable in the current EQR 2022. (Refer to Table 2-29 for UnitedHealthcare's performance in EQR 2022.)

Table 2-30. Degree of response to EQRO's previous recommendations

Previous Recommendation	Action by UnitedHealthcare	UnitedHealthcare's Degree of Response and EQRO's Recommendations
EQR 2021		
1. Study Population: UnitedHealthcare should articulate the concepts and clearly define the target population and PIP population. The PIP population should be selected at a small scale (e.g., from a county, provider office, or region) so that results can be measured during the PDSA cycle and subsequently applied at a larger scale.	The issue remained in the EQR 2022.	**Low** The same recommendation applies to the EQR 2022.
2. Variables/secondary measures: Data elements collected after the intervention should be clearly and accurately defined along with units	Secondary measures were defined accurately for both the PIPs. However, the	**Medium** The same recommendation

Previous Recommendation	Action by UnitedHealthcare	UnitedHealthcare's Degree of Response and EQRO's Recommendations
of measure and correctly utilized to analyze the PIP results.	variables were not accurate.	applies to the EQR 2022.
3. Data Collection Procedures: UnitedHealthcare must address the data collection sources and specify if they used data for inpatients, primary care providers, specialty care providers, ancillary service providers, Electronic Health Records (EHR), and if the data collection included encounter/utilization data for all the services provided.	No action was taken. The issue remains in the EQR 2022	**Low** The same recommendation applies to the EQR 2022.
4. PDSA Cycles: UnitedHealthcare must adopt PDSA cycles that involve analysis, feedback/lessons learned from the data collected after the intervention, and application of these outcomes to plan another test cycle.	Though UnitedHealthcare reported using the PDSA cycles for both the PIPs, PTM determined that the process was not followed.	**Low** The same recommendation applies to the EQR 2022.
5. Sustained improvement: After an intervention is implemented and results are analyzed, UnitedHealthcare should identify strategies to create a sustained improvement. This allows UnitedHealthcare to maintain the positive results of the intervention, correct negative results, and scale the intervention to support longer-term improvements or broader improvement capacity across other health services, populations, and aspects of care. Because PIPs can be resource-intensive, this phase also helps learn how to allocate more efficiently for future projects.	UnitedHealthcare did not meet the requirements for both PIPs. The interventions were ongoing without demonstrating improvement.	**Low** The same recommendation applies to the EQR 2022. In addition, a target should be set for the intervention based on the goal of the PIP. The intervention should be adopted, adapted, or abandoned with each PDSA cycle based on the results obtained.

Previous Recommendation	Action by UnitedHealthcare	UnitedHealthcare's Degree of Response and EQRO's Recommendations
EQR 2020		
1. Even though the MHD mandates an overarching goal, UnitedHealthcare can select a topic within specified parameters. To ensure a successful PIP, UnitedHealthcare should find early and regular opportunities to obtain input from staff, providers, and members on improving care delivery.	There was some improvement towards this step in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022. Additionally, UnitedHealthcare must mention explicitly whether the PIP included special populations or high-priority services.
2. UnitedHealthcare should translate the aim statement to identify the focus of the PIP and establish the framework for data collection and analysis on a small scale (PDSA cycle).	There was no improvement in this step in the methodology of PIP.	**Low** The same recommendation applies to EQR 2022.
3. UnitedHealthcare should select a variable (a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied) that could identify UnitedHealthcare's performance on the PIPs and track improvement over time. UnitedHealthcare can use focus groups, surveys, and interviews to collect qualitative insights from members, MCO and provider staff, and key external partners. Qualitative measures can serve as secondary measures or supplement the overall measurement set, providing information that will aid PIP planning and implementation.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.

Previous Recommendation	Action by UnitedHealthcare	UnitedHealthcare's Degree of Response and EQRO's Recommendations
4. UnitedHealthcare should have variables/secondary measures that should tie an intervention to improvement. For example, after sending DCOR reports in ADV PIP, UnitedHealthcare should measure the % of appointments scheduled from the DCOR list and % of members responding by visiting a dentist.	There was an improvement in this step of PIPs' methodology.	**Medium** The same recommendation applies to EQR 2022.
5. Repeat measurements (at least two) in short intervals (unlike 90-day intervals selected in ADV PIP) should be conducted to determine whether significant performance changes relative to baseline measurement were observed.	There was an improvement towards this step in the methodology of PIP in EQR 2022.	**High**
6. Effectiveness of the improvement strategy should be determined by measuring a change in performance according to the predefined measures and linking to intervention.	There was no improvement towards this step in the methodology of PIP in EQR 2022.	**Low** The same recommendation applies to EQR 2022.
7. When analyzing multiple data points over time, UnitedHealthcare should consider tools such as time series, run charts, control charts, data dashboards, and basic trend analyses.	Data was primarily presented using Tables.	**Low** UnitedHealthcare should use the tools recommended in this section for the PIPs to show the intervention results and the baselines.
EQR 2019		
1. UnitedHealthcare must refine its skills in the development and implementation of approaches to effect change in the PIPs.	There was some improvement in the methodology of PIP in EQR 2022.	**Medium** The same recommendation applies to EQR 2022.

Previous Recommendation	Action by UnitedHealthcare	UnitedHealthcare's Degree of Response and EQRO's Recommendations
2. The interventions should be planned specifically for PIP required by the MHD Contract.	There was some improvement. However, the interventions were ongoing even when no improvement was evident.	**Medium** The same recommendation applies to EQR 2022.
3. The results should be tied to the interventions.	No improvement was seen.	**Low** The same recommendation applies to EQR 2022.

2.5 Recommendations for MCOs

Table 2-31 displays PTM's recommendations (with numbers corresponding to the listed items) applicable to Home State Health, Healthy Blue, and UnitedHealthcare.

Table 2-31. Recommendations applicable (✓) for MCOs

Recommendations No:	Home State Health	Healthy Blue	UnitedHealthcare
1.	✓	✓	✓
2.	✓	✓	✓
3.	✓	-	✓

1. The MCOs must improve the methodology for its PIPs to meet the compliance requirements set in 42 CFR 438.330(d)(2)/MHD contract, section 2.18.8(d). Also, recommendations from the previous years scored as "Low" and "Medium" must be addressed (Tables 2-7, 2-14, 2-30).

2. Sampling: Accurate knowledge of sampling must be applied while conducting PIPs.

3. Data Analysis and Interpretation of PIP results: The baseline corresponding to the parameters under study must be provided from the previous year to see the trend over a period.

3.0 VALIDATION OF PERFORMANCE MEASURES

3.1 Objective and Technical Method

Validation of MCOs' performance measures in the preceding 12 months as required per the 42 CFR 438.358(b)(1)(ii) was the objective in the EQR 2022. PTM validated a set of performance measures identified by the MHD, calculated and reported by Home State Health, Healthy Blue, and UnitedHealthcare for their managed care population. The MHD identified the measurement period as the calendar year (CY) 2021/Measurement year (MY) 2021. The performance measures selected by the MHD for validation were as follows:

- Chlamydia Screening in Women (CHL).
- Well-Child Visits in the First 30 Months of Life (W30).
- Follow-Up After Hospitalization for Mental Illness-30 days post-discharge (FUH-30 days).

All the performance measures selected by the MHD were administrative only, which required primary source verification (PSV) from the MCOs' administrative systems (claims and supplemental data).

PTM conducted the validation process in accordance with the CMS publication, EQR Protocol 2, Validation of Performance Measures, and Appendix A, Information Systems Capabilities Assessment (ISCA), for each MCO.

PTM assessed the MCOs for the following:

- Accuracy of the performance measures based on the measure specifications and State reporting requirements.
- Compliance with the rules outlined by the MHD for calculating the performance measures.
- Information Systems underlying performance measurement.
- Accuracy of data integration and control for performance measures calculation.
- Accuracy of performance measure production.
- Ability to process claims, enrollment, provider, and supplemental data accurately.
- MCOs' ability to identify numerator and denominator eligible members accurately.
- Adequacy of processes to ensure data completeness and quality.

Pre-Audit Process

PTM prepared a series of electronic communications that were submitted to the MCOs on May 5, 2022, outlining the steps in the performance measure validation process based on CMS Performance Measure Validation Protocol 2. The electronic communications included a request for samples, numerator and denominator files, and a completed Information

System Capability Assessment (ISCA). Additionally, PTM requested any supporting documentation required to complete the performance measure validation review. The communications addressed the Simple Random methodology of selecting a maximum of 45 records for PSV and the process for sampling and validating the administrative measures during the review process. PTM provided specific questions to the MCOs during the measure validation process to enhance the understanding of the ISCA responses during the virtual site visit.
PTM submitted an agenda prior to the virtual visit describing the activities and suggested that subject matter experts attend each session. PTM exchanged several pre-onsite communications with the MCOs to discuss expectations, virtual session times and to answer any questions that MCOs may have regarding the overall process.

Data Collection and Analysis

The CMS performance measure validation protocol identifies key components that should be reviewed as part of the validation process. The following points describe these components and the methodology used by PTM to conduct its analysis and review:

- ISCA: The MCOs completed and submitted the required and relevant portions of their ISCA for PTM's review. PTM used responses from the ISCA to complete the onsite and pre-onsite assessment of their information system.
- Source code verification for performance measures: The MCOs contracted with a software vendor to generate and calculate rates for the three administrative performance measures, CHL, W30, and FUH-30 days.
- Additional supporting documents: In addition to reviewing the ISCA, PTM also reviewed the MCOs' file layouts, system flow diagrams, system files, and data collection processes. PTM reviewed all supporting documentation and identified any issues requiring further clarification.
- Administrative rate verification: Upon receiving the numerator and denominator files for each measure from the three MCOs, PTM conducted a validation review to determine reasonable accuracy and data integrity.
- PTM drew a sample of 45 administrative claims for each administrative measure, CHL, W30, and FUH-30 days, and conducted primary source verification to validate and assess the MCOs' compliance with the numerator objectives.

Virtual Site Activities

PTM conducted virtual site meetings with UnitedHealthcare on July 14, 2022; Healthy Blue on July 18, 2022; and Home State Health on July 20, 2022. The information was collected using several methods, including interviews, system demonstrations, review of data output

files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- Opening Conference: The opening meeting included an introduction of the validation team and MCOs' key staff members involved in the performance measure validation activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- Review Information System Underlying Performance Measurement: The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure rates, including accurate numerator and denominator identification and algorithmic compliance, which evaluated whether a) rate calculations were performed correctly, b) data were combined appropriately, and c) numerator events were counted accurately.
- ISCA Review, Interviews, and Documentation: The review included processes used for collecting, storing, validating, and reporting performance measure rates. The review meetings were interactive with the key staff members to capture MCOs' steps to generate the performance measure rates. PTM used this session to assess a confidence level in the reporting process and performance measure reporting as well as the documentation process in the ISCA. In addition, PTM conducted interviews to confirm findings from the documentation review and to ascertain that written policies and procedures were used and followed in daily practice.
- Assess Data Integration and Control Procedures: The data integration session comprised of system demonstrations of the data integration process and included discussions around data capture and storage, reviewing backup procedures for data integration, and addressing data control and security procedures.
- Complete Detailed Review of Performance Measure Production: PTM conducted primary source verification to further validate the administrative performance measures.
- Closing Conference/Communicate Preliminary Findings: The closing conference included a summation of preliminary findings based on the review of the ISCA and the site visit.

Validation Process

The MHD instructed the MCOs to utilize the HEDIS specifications for the CHL, W30, and FUH 30 Days.

As part of the performance measure validation process, PTM reviewed the MCOs' data integration, data control, and documentation of performance measure rate calculations. These are crucial to the validation process. The validation processes utilized and the validation findings are described as follows. The scoring criteria (Table 3-1) are adopted

from the CMS EQR Protocol 2.

Table 3-1. Scoring Criteria for Performance Measures	
Met	The MCO's measurement and reporting process was fully compliant with State specifications.
Not Met	The MCO's measurement and reporting process was not fully compliant with State specifications. This designation should be used for any validation component that deviates from the State specifications, regardless of the impact of the deviation on the final rate. All components with this designation must include an explanation of the deviation in the comments section.
N/A	The validation component was not applicable.

Data Integration

Data integration is an essential part of the overall performance measurement creation/reporting process. Data integration relies upon various internal systems to capture all data elements required for reporting. Accurate data integration is essential for calculating valid performance measure rates. PTM reviewed the MCOs' actual results of file consolidations and extracts to determine if they were consistent with those which should have demonstrated results according to documented specifications. The steps used to integrate data sources such as claims and encounter data, eligibility, and provider data require highly skilled staff and carefully controlled processes.
PTM validated the data integration process used by Home State Health, Healthy Blue, and UnitedHealthcare, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms.

Data Control

Data control procedures ensure accurate, timely, and complete data integration into the performance measure database by comparing data samples in the repository with transaction files. Good control procedures determine if any members, providers, or services are lost in the process and if the organization has methods to correct lost/missing data. The organization's infrastructure must support all necessary information systems and backup procedures. PTM validated the data control processes the MCOs used, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures.
PTM determined that the MCOs' data control processes were acceptable.

Performance Measure Documentation

Sufficient and complete documentation is necessary to support validation activities. While interviews and system demonstrations provided the necessary information to complete the audit, the majority of the validation review findings were based on documentation provided by the MCOs in the ISCA. PTM's Lead Auditor reviewed the computer programming codes, output files, workflow diagrams, primary source verification, and other related documentation.

Performance Measure Specific Findings

PTM determined validation results for each performance measure based on the below definitions. The validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Met." Consequently, it is possible that an error for a single audit element may result in a designation of "Do Not Report (DNR)" because the impact of the error materially biased the reported performance measure. Conversely, it is also possible that several audit element errors may have little impact on the reported rate. Thus the measure is "Reportable (R)." The following is a list of the validation findings and their corresponding definitions:
R = Reportable: Measure was compliant with State specifications.
DNR = Do not report; the MCO's rate was materially biased and should not be reported.
NA = Not applicable; the MCO was not required to report the measure.
NR = Measure was not reported because the MCO did not offer the required benefit.

3.2 Findings, Analysis, and Conclusions: Home State Health

PTM evaluated Home State Health's data systems for processing each data type used for reporting the MHD performance measure rates. General findings are indicated below.

Medical Service Data (Claims and Encounters)

PTM reviewed Home State Health's claims process and verified that no significant changes were made from the previous year's review. Home State Health used AMISYS as its primary claims processing system. AMISYS captured all relevant fields required for performance measure reporting, capturing only standard codes using standard electronic and paper claims.
Home State Health continued to capture most of its claims electronically. The small number of paper claims received were scanned and converted into electronic format before being submitted to AMISYS for adjudication.

Home State Health continued to have less than 5% manual intervention for claims processing. Most of the manual steps in processing were due to high-dollar claims that required supervisor approval. As in previous audits, PTM confirmed that Home State Health only used standard coding such as CPT-4, HCPCS, and ICD-10.
Home State Health's AMISYS system captured primary, secondary, and modifier codes appropriately. Coding updates to the AMISYS system were made annually to ensure the most recent coding schemes were captured. Home State Health had minimal capitation arrangements for services, having ninety-nine percent of all claims submitted based on a Fee-For-Service arrangement.
PTM had no concerns with Home State Health's claims and encounter data processes.

Enrollment Data

Home State Health used the AMSISY system to capture enrollment information for its members. The AMISYS system contained relevant fields necessary for identifying member demographic information as well as enrolment spans and primary care provider assignment. PTM confirmed no changes to the enrollment process from the previous year. Home State Health experienced moderate growth year over year and continued to receive enrollment files from the State in standard electronic 834 files. PTM confirmed no backlogs of enrollment files during the measurement year. Home State Health acknowledged that manual data entry of enrollment information occurred less than 1% of the time.
Home State Health conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority.
During the virtual review, PTM verified that the members captured in the performance measures were the appropriate populations, and no issues were found.
PTM had no concerns with Home State Health's ability to capture member information.

Provider Data

Home State Health continued utilizing two systems for provider processing: Portico and AMISYS. Provider files were first loaded into Home State Health's Portico system, where the provider began the credentialing process. Once the provider was credentialed, the provider information was loaded into AMISYS. Home State Health has a process for validating provider information daily to ensure both systems contained the same demographic information. Specialties were validated in Portico and then matched with AMISYS.
The unique provider identification number linked the two systems used by Home State Health. Besides provider maintenance, no significant system changes were made during the measurement year.

PTM verified that provider specialties were captured accurately. In addition, PTM validated that all providers operating in Home State Health's network were licensed to operate under the Medicaid Managed Care contract for the MHD.
AMISYS maintained all relevant information required for performance measure reporting.
Both Portico and AMISYS contained unique identifiers and captured identical information as expected.
There were no updates or changes to Home State Health's provider data processes, including how it captured provider data through its delegated entities.
PTM did not have any concerns with Home State Health's provider process related to creating performance measures.

Medical Record Review Validation (MRRV)

Medical record review was not part of the review for MY 2021 as the measures under review were strictly administrative only measures and did not require a medical record component.

Supplemental Data

Numerator positive hits through supplemental data sources CHL, W30, and FUH-30 days were considered standard administrative records. PTM had no concerns with the data sources or record acquisition.

Data Integration

Home State Health continued to use Inovalon's Quality Spectrum Insights (QSI)-XL software for performance measure reporting.
Home State Health creates monthly data loads and continuously validates QSI-XL's quality reports to verify that data were captured appropriately. Any missing data files or segments were promptly reconciled before measure creation.
Home State Health had a two-step validation process that logged records submitted with the file name and record counts. Files with the same name were matched against each other to determine if the record counts matched. The second-tier validation looked to determine error counts and error reasons.
Home State Health conducted a full refresh of data each month rather than incremental data loads.
Home State Health continued to monitor rate changes using month-over-month comparison reports to ensure data were complete and accurate and to identify gaps in care.
PTM did not find any issues during the primary source verification process.

PTM had no concerns with Home State Health's ability to consolidate files and report performance measures accurately.

Home State Health Performance Measure Rates

Tables 3-2 to 3-4 show the results of the performance measures in the format based on the CMS EQR Protocol 2.

Table 3-2. Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	2,972	4,314	6,842
Denominator	6,170	9,395	14,366
Rate	**48.17%**	**45.92%**	**47.63%**

Table 3.3. Performance Measure Results Well-Child Visits in the First 30 Months of Life (W30)			
Data Element/MY	**2019**	**2020**	**2021**
First 15 Months Numerator	NA	3,686	5,100
First 15 Months Denominator	NA	7,729	10,420
First 15 Months Rate	NA	**47.69%**	**48.94%**
15 – 30 Months Numerator	NA	3,806	4,684
15 – 30 Months Denominator	NA	5,729	8,313
15 – 30 Months Rate	NA	**66.43%**	**56.35%**

Table 3-4. Follow-Up After Hospitalization for Mental Illness (FUH-30 Days)*			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	1,203	1,086	1180
Denominator	2,233	2,131	2846
Rate	**53.87%**	**50.96%**	**41.46%**

*PTM did not validate results for MY 2019-2020

3.2.1 Quality, Timeliness, and Access

Strengths.

- Home State Health staff was well prepared for a site review and had all claims and preparation completed ahead of schedule.
- Home State Health updates the AMISYS systems with the most current diagnoses and procedures as they become available during the year.

- Home State Health completed the primary source verification process without any errors.
- Home State Health was able to demonstrate its ability to capture the specific diagnosis codes for CHL, W30, and FUH-30 Days.
- Home State Health continues to monitor and improve the data capture in both primary and supplemental data for numerator compliance.
- Home State Health showed marginal improvement in both CHL (1.53% points) and W30 in the 0-15 months cohort (1.25% points) for MY 2021 (Tables 3-2, 3-3).

Weakness. Home State Health's W30 rate for age cohort 15-30 months dropped significantly from 66.43% (MY 2020) to 56.35% (MY 2021) by 10.08% points. Although PTM didn't validate the FUH-30 days in the previous two years, Home State Health's FUH-30 days significantly dropped (9.5% points) from 50.96% (MY 2020) to 41.46% (MY 2021).

3.2.2 Improvement from previous year

Response to Previous Year's Recommendations. Table 3-5 describes actions taken by Home State Health in response to EQRO recommendations during the previous EQR 2021. PTM evaluated Home State Health's response and categorized it as High, Medium, and Low. (The definitions of these categories are the same as described earlier in section 2.1 of this report.)

Table 3-5. Home State Health's Response to Previous Year's Recommendations

EQRO Recommendation	Action by Home State Health	Degree of Response
PTM continues to recommend that Home State Health improve outpatient mental health services and educate the members to have a follow-up visit to a doctor within seven days and thirty days post-hospital discharge.	Home State Health should facilitate the scheduling of follow-up visits for the member. Home State Health showed a significant decrease of 9.5% points from the previous year, which indicates significant issues with follow-up visit compliance.	**Low** Home State Health should focus efforts on increasing compliance with this measure and should set up the member's initial outpatient visit with a mental health provider following discharge.

Home State Health should consider incentivizing providers to meet with members for the W30 measure. This may positively impact the rates for future years.	Home State Health was not successful at increasing compliance. Home State Health's rate significantly decreased year over year by 10.08% for the 15-30 months age cohort.	**Low** No improvement was noted for this measure.
PTM recommends Home State Health continue education and outreach efforts to members and providers to increase Chlamydia screenings.	Home State Health showed a marginal increase of 1.71% points in CHL screening year over year, indicating a small but positive impact. Home State Health should provide additional guidance to providers for testing.	**Medium** Home State Health should provide additional guidance or incentives to the providers for testing.

3.3 Findings, Analysis, and Conclusions: Healthy Blue

PTM evaluated Healthy Blue's data systems for processing each data type used for reporting the MHD performance measure rates. General findings are indicated below.

Medical Service Data (Claims and Encounters)

Anthem, Inc. acquired Missouri Care effective Jan 23, 2020, and began processing claims on its transactional claim system Facets during the measurement year. All claims data submitted by providers were either submitted electronically using standard 837 format or via paper. Any paper claims that were submitted to Healthy Blue were scanned and converted into 837 electronic transactions prior to loading into the Facet system. All claims, whether paper or electronic, are subjected to the same Health Insurance Portability and Accountability Act of 1996 (HIPAA) and benefit edits prior to being adjudicated. All claims must include standard procedure and diagnosis codes. Additionally, the Facets system requires valid member and provider detailed information. Claims that are missing required fields are rejected back to the provider for correction. All fields required for adjudication are mapped from the original claim transaction into the adjudication system, where the processing screens integrate provider-submitted and adjudication information. The provider-submitted and system-assigned data can be distinguished based on the

naming convention of the fields within the system. The field names within the adjudication system will align the individual claim elements on a provider-submitted claim.

As claims are processed through the nightly batch cycle, edits are applied. If the claim successfully passes all edits, it is set to pay and will be processed on the next scheduled payment cycle. If a claim contains an edit that requires manual review, a claim analyst will apply appropriate processing instructions to finalize the claim. The claim then posts to the next payment cycle.

Any claim that does not auto-adjudicate is routed to an online queuing system for additional review using the MACESS EXP Doc-Flo. Claims are automatically routed to the appropriate queue based on the reason for suspension. This system is also configured to distribute claims using first-in, first-out (FIFO) inventory management. Claim Analysts for the Missouri market were assigned to a queue based on their experience level and volume. Inventory reports are generated each day by each market detailing the numbers of claims in pend by age categories. Inventory reports are available on demand and utilized by management throughout the day to ensure claims are processed timely. This allows Healthy Blue to quickly react to any fluctuations in claim submittals and pends. Once a claim is resolved, it will automatically post to the next twice-per-week payment cycle. All claims that do not pass due to lack of authorization are pended for manual review. Business rules are set for certain claim types that will cause the claim to pend for manual review outside of basic editing rules. The claims analyst will apply the specific processing instruction to resolve any issues. Examples of additional business rules that cause pending claims are hysterectomy, sterilization, and abortion services for a consent form, high dollar, coordination of benefits (COB), other health insurance (OHI) verification, and timely filing requirements.

Inventory reports are generated each day from Healthy Blue's inventory Management System (MACESS) by market, detailing the number of claims in a pended status by aging categories. Inventory reports are available on demand and utilized by management throughout the day to ensure claims are processed timely. MACESS EXP doc-flow is a workflow claim inventory management system. The system will evaluate the pend reason on a claim and distribute the work item to a queue. Work items will continue to populate the queues until the pended claim is resolved and the claim is paid. These reports are distributed throughout the company to ensure the 'queue' owners understand the volume and age of the claims in their queues and to ensure the meeting of internal service level agreements. Healthy Blue staff indicated that approximately 87% of all claims auto adjudicate, and the remaining 13% pend for manual intervention.

PTM services did not have any concerns with Healthy Blue's ability to accurately capture and process claims during the measurement year. Health Blue was fully compliant with claims processing.

Enrollment Data

Healthy Blue began processing enrollments on the Facets system during the measurement year.
Healthy Blue received the daily enrollment files in a standard HIPAA-compliant 834 electronic format and loaded the files directly into Facets. Healthy Blue reconciled the daily files with a monthly file, also provided by the State, to ensure data were accurate prior to enrolling the member. PTM reviewed the Facets system during the site audit and confirmed that each enrollment span was captured. Additionally, PTM reviewed several enrollment records to ensure that all HEDIS-required data elements were present and accurate. PTM conducted drill-downs examining the enrollment process and enrollment spans for all Healthy Blue members. Additional queries looked at the length of enrollment for all members. The average length of time a member was continuously enrolled was 11 months or more, which was consistent with the last review PTM conducted. Healthy Blue reported having no issues with the enrollment process during the measurement year.

Healthy Blue conducted appropriate oversight of the enrollment process through ongoing internal audits and communication with the State enrollment authority. PTM confirmed there were no changes to Healthy Blue's enrollment data process since the previous year's review. The enrollment system contains all the fields needed for capturing relevant performance measure information.

PTM selected a sample of 45 members from several administrative numerators and verified that the members were compliant with the measure specifications. PTM verified age, gender, and enrollment history, along with diagnosis and procedure codes. No issues were found during the system review. During the virtual review, PTM verified that the members captured in the performance measures were the appropriate populations.
PTM had no concerns with Healthy Blue's ability to capture member information.

Provider Data

Healthy Blue utilized Facets to capture its provider data for claims processing. Healthy Blue utilized both direct contracted and delegated entities to enroll providers. Healthy Blue used a unique provider identifier in Facets which also linked to the provider practicing specialty. Healthy Blue's credentialing staff ensured provider specialties were appropriate by

validating the provider's education and specialty assignment authorized by the issuing provider board. PTM verified that the required HEDIS reporting elements were present in Facets and provider specialties were accurate based on the provider mapping documents submitted with Healthy Blue's ISCA.

All providers were appropriately credentialed in the specialties in which they were practicing. Healthy Blue followed strict credentialing verification to ensure providers did not have any sanctions or criminal activity. In addition, all verification included background checks for each provider prior to committee approval. PTM reviewed provider specialties to ensure the specialties matched the credentialed providers' education and board certification. PTM found Healthy Blue to be compliant with the credentialing and assignment of individual providers at Federally Qualified Health Centers (FQHCs). Healthy Blue captured all relevant provider information to identify for accurate performance measure reporting.
Healthy Blue was fully compliant with provider data controls and specialties related to performance measurement reporting.

Medical Record Review Validation (MRRV)

Medical record review was not part of the review for MY 2021 as the measures under review were strictly administrative only measures and did not require a medical record component.

Supplemental Data

Numerator positive hits through supplemental data sources CHL, W30, and FUH-30 days were considered standard administrative records. PTM had no concerns with the data sources or record acquisition.

Data Integration

Healthy Blue continued to use Inovalon software for performance measures, QSI-XL. Healthy Blue indicated no significant issues with the migration, and no concerns were identified during on-site primary source verification.
Healthy Blue's internal data warehouse combined all files for uploading into QSI-XL's certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into QSI-XL file layouts. The majority of information was derived from the Facets system, while external data, such as supplemental and vendor files, were loaded directly into the data warehouse tables. PTM

conducted a review of the HEDIS data warehouse and found it to be compliant. Healthy Blue had several staff members involved in the process with many years of experience dealing with data extractions, transformations, and loading. The warehouse continued to be managed well, and access was only granted when required for job duties.
PTM conducted primary source verification and did not encounter any issues during the validation. Member data matched Facets, the data warehouse, and Inovalon numerator events. PTM also conducted a series of queries during the site audit and did not identify any issues. PTM reviewed Healthy Blue's final rates and did not identify any concerns.

Healthy Blue maintains an Enterprise Data Warehouse and runs performance measures monthly in a prospective and retrospective manner. Healthy Blue utilizes industry-standard processes to maintain and update input data for QSI XL (Inovalon, Inc.), including automated processes for consolidating and loading supplemental data. Healthy Blue reviews data quality reports identifying loading errors and ensuring complete data consolidations. Following each monthly process, Healthy Blue runs rate comparisons to benchmark rates. If rates seem out of line, Healthy Blue investigates the process to determine data integrity and quickly resolves any outstanding issues. Healthy Blue staff conduct routine monitoring to ensure the quality and accuracy of the consolidation processes. Healthy Blue routinely conducts primary source verification to ensure data is accurately transferred from source to target.
PTM Services had no issues with Healthy Blue's ability to accurately consolidate files for performance measurement reporting.

Healthy Blue Performance Measure Rates

Tables 3-6 to 3-8 show the results of the performance measures in the format based on the CMS EQR Protocol 2.

Table 3-6. Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	1,909	2,708	7,258
Denominator	5,899	9,195	16,291
Rate	32.36%	29.43%	44.55%

Table 3-7. Performance Measure Results			
Well-Child Visits in the First 30 Months of Life (W30)			
Data Element/MY	**2019**	**2020**	**2021**
First 15 Months Numerator	NA	4,238	6,206

First 15 Months Denominator	NA	8,163	12,411
First 15 Months Rate	NA	**51.92%**	**50.00%**
15 – 30 Months Numerator	NA	3,571	5,899
15 – 30 Months Denominator	NA	4,995	9,641
15 – 30 Months Rate	NA	**71.49%**	**61.19%**

Table 3-8. Follow-Up After Hospitalization for Mental Illness (FUH-30 Days)*			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	1,422	1,267	1,824
Denominator	2,385	2,252	3,156
Rate	59.62%	56.26%	57.79%

*PTM did not validate results for MY 2019-2020

3.3.1 Quality, Timeliness, and Access

Strengths.

- Healthy Blue staff was well prepared for a site review and had all claims and preparation completed ahead of schedule.
- Healthy Blue demonstrated and articulated its knowledge and experience of the measures under review.
- Healthy Blue updates the Facets system with the most current diagnoses and procedures as they become available during the year.
- Healthy Blue did not appear to have provider barriers to care for the CHL, W30, and FUH-30 days.
- Appropriate services, such as laboratory, primary care, and hospital access, are readily available in all regions. Admission to hospitalization requires proper authorization, and participating hospitals are well informed of the process for obtaining authorizations from Healthy Blue.
- Healthy Blue was able to demonstrate its ability to capture the specific diagnosis codes for each CHL, W30, and FUH-30 days.
  Healthy Blue continues to monitor and improve upon the data captured in both primary and supplemental data for numerator compliance.
- Healthy Blue's CHL rate significantly improved from 29.43% (MY 2020) to 44.55% (MY 2021) by 15.12% points (Table 3-6).

Weakness. Healthy Blue's W30 rate for the age cohort 15-30 months dropped significantly from 71.49% (MY 2020) to 61.19% (MY 2021). Healthy Blue indicated that the

rate difference might have been attributed to continued COVID-19 fear.
Although PTM services didn't validate the FUH-30 days in the previous two years, Healthy Blue's FUH-30 days trended down slightly (1.83% points) compared to MY 2019. While the trend is not considered statistically significant, being less than a 5% point difference, it should be considered a potential issue.

3.3.2 Improvement from previous year

Response to Previous Year's Recommendations. Table 3-9 describes actions taken by Healthy Blue in response to EQRO recommendations during the previous EQR 2021. PTM evaluated Healthy Blue's response and categorized it as High, Medium, and Low. (The definitions of these categories are the same as described earlier in section 2.1 of this report.)

Table 3-9. Healthy Blue's Response to Previous Year's Recommendations

EQRO Recommendation	Action by Healthy Blue	Degree of Response
PTM continues to recommend Healthy Blue pursue outpatient mental health services and educate the members to have a follow-up visit to a doctor within seven days and thirty days post-hospital discharge.	Healthy Blue should facilitate scheduling follow-up visits for its members. Healthy Blue increased by 1.53% from the previous year, but this was not a significant change.	**Medium** There is still scope for improvement in this measure.
Healthy Blue should consider incentivizing providers to meet with members for the W30 measure. This may positively impact the rates for future years.	Healthy Blue's rate significantly decreased year over year by 10.3%.	**Low** No improvement was noted in this measure.
PTM recommends that Healthy Blue continues education and outreach efforts to members and providers to increase Chlamydia screenings.	Members were outreached throughout the year and educated to seek CHL screenings. Healthy Blue showed a significant increase of 15.12% in CHL screening year over year.	**High** There was a positive impact on outreach with members and providers.

3.4 Findings, Analysis, and Conclusions: UnitedHealthcare

PTM evaluated UnitedHealthcare's data systems for processing each data type used for reporting the MHD performance measure rates. General findings are indicated below.

Medical Service Data (Claims and Encounters)

UnitedHealthcare's continued to use the Facets system during MY 2021. UnitedHealthcare only updated the procedure and diagnosis coding along with the usual maintenance of Facets during the MY 2021. These coding updates were done annually. PTM confirmed that UnitedHealthcare only used standard paper claim forms, CMS-1500 and UB-04, and standard 837P and 837I for electronic submissions. All paper claims are scanned by UnitedHealthcare's scanning vendor and converted to electronic format. United Healthcare does not accept paper claims for manual entry. PTM also confirmed that all vendors used these standard claim forms. UnitedHealthcare was able to distinguish between the primary and secondary coding schemes. Incomplete claims submitted from providers were promptly rejected and returned for additional information. Incomplete claims were not allowed in the claims system until all required fields were present and valid.
UnitedHealthcare's pre-processing edits verified the accuracy of submitted information on all claims and encounters. Claims containing errors such as invalid Current Procedural Terminology (CPT) or diagnosis codes were rejected and returned to the service provider for correction. There were no circumstances where a processor could update or change the values on a submitted claim. All medical and behavioral claims were processed using industry-standard paper and electronic means. Medicaid claims were audited regularly for financial and procedural accuracy by randomly selecting thirty-two (32) claims on a weekly basis to validate accuracy and data quality. Quality errors are rectified, and additional training is provided to the claims examiners when issues arise.
Facets provided the claims examiner with specific error messages when a pre-authorization request did not match the service rendered by the provider or when the provider did not request a pre-authorization prior to rendering the service. In either circumstance, the claim required a medical review and was pended for Utilization Management for review. UnitedHealthcare staff denied having any issues with backlogs or delays during the measurement year.
UnitedHealthcare's processing timeliness standards were to process 90 percent of clean claims within 30 days of receipt and 99 percent of clean claims within 90 days of receipt. UnitedHealthcare maintained that 99 percent of all claims were processed within 90 days. There were no significant changes to any claims process for UnitedHealthcare during the measurement year. PTM had no concerns with UnitedHealthcare's claims/encounter processing.

Enrollment Data

UnitedHealthcare received weekly enrollment files in standard 834 electronic transactions from the State. Each file was validated prior to being loaded into Facets. The Facets system created a member record for new members and made the necessary updates to existing member information. United performed audits to ensure the enrollment process was accurate. The member's enrollment spans were captured for reporting and combined to assess continuous enrollment. UnitedHealthcare was able to identify and correct duplicate member records following verification with the State enrollment files. UnitedHealthcare's time to process was 24 hours from receipt of the enrollment file. All downstream vendors received an updated enrollment file daily and a complete file monthly following processing at UnitedHealthcare. There were no changes to the enrollment process from the previous year's review. There were no issues identified with UnitedHealthcare's enrollment data processes as it pertains to performance measurement.
PTM had no concerns with UnitedHealthcare's ability to capture member information.

Provider Data

UnitedHealthcare processed provider data in the Network Database (NDB) and Facets. Provider information was initially entered into NDB, and data transmissions from NDB to Facets were automatically performed nightly to update the information in the claims system. System reconciliations were performed daily to ensure data consistency. United conducted several provider data audits, including provider set-up audits, end-to-end audits, and focused audits.
UnitedHealthcare continued to update its provider directories weekly. A weekly provider feed is sent to their vendor to update the most current provider data. This allows a member to receive a current directory when requested. Members can call Customer Service and request a weekly updated directory via mail. The NDB is a primary source for the provider directory, and data entered there flows through UnitedHealthcare's other systems in a standard process.
PTM reviewed the process for mapping provider specialties and verified primary care specialties during the virtual site review and primary source verification session. All provider specialties matched the certified provider taxonomy. UnitedHealthcare was compliant with the credentialing standards and credentialed individual providers at the Federally Qualified Health Centers (FQHCs).
There were no changes to UnitedHealthcare's provider data processes, including how it captured provider data through its delegated entities.
PTM did not have any concerns with UnitedHealthcare's provider processes related to creating performance measures.

Medical Record Review Validation (MRRV)

Medical record review was not part of the review for MY 2021 as the measures under review were strictly administrative only measures and did not require a medical record component.

Supplemental Data

Numerator positive hits through supplemental data sources CHL, W30, and FUH-30 Days were considered standard administrative records. PTM had no concerns with the data sources or record acquisition.

Data Integration

UnitedHealthcare continued to use Inovalon software for performance measures, QSI-XL. UnitedHealthcare indicated no significant issues with the migration, and no concerns were identified during on-site primary source verification.
UnitedHealthcare's internal data warehouse combined all files for uploading into QSI-XL's certified measures software. The internal data warehouse combined all systems and external data into tables for consolidation prior to loading into QSI-XL file layouts. The majority of information was derived from the Facets system, while external data, such as supplemental and vendor files, were loaded directly into the data warehouse tables. PTM conducted a review of the HEDIS data warehouse and found it to be compliant with data warehousing standards.
Facets and encounter data were linked using unique identifiers in Facets linking all other identifiers from external sources such as State Medicaid identifiers and social security numbers. All identifiers were tracked and captured in a central data warehouse where they linked members with their encounter and claims transactions.
UnitedHealthcare utilized senior analysts or managers to examine and approve code for quality and validation. Results were compared to the prior year's metrics when available or Medicaid benchmarks to determine the reasonableness of results. Per UnitedHealthcare's maintenance cycle, data was reviewed and validated by the assigned analyst and the business owner after requirements were verified and approved. There were no critical errors detected in any of the measures under review.
PTM Services did not have any issues with UnitedHealthcare's ability to accurately consolidate files for performance measurement reporting.

UnitedHealthcare Performance Measure Rates

Tables 3-10 to 3-12 show the results of the performance measures in the format based on the CMS EQR Protocol 2.

Table 3-10. Chlamydia Screening in Women All Ages (CHL)			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	2,275	3,727	5,304
Denominator	4,921	8,232	10,573
Rate	46.23%	45.27%	50.16%

Table 3-11. Performance Measure Results Well-Child Visits in the First 30 Months of Life (W30)			
Data Element/MY	**2019**	**2020**	**2021**
First 15 Months Numerator	NA	3,412	4,535
First 15 Months Denominator	NA	7,330	8,805
First 15 Months Rate	NA	**46.55%**	**51.50%**
15 – 30 Months Numerator	NA	2,943	3,781
15 – 30 Months Denominator	NA	4,558	6,377
15 – 30 Months Rate	NA	**64.57%**	**59.29%**

Table 3-12. Follow-Up After Hospitalization for Mental Illness (FUH- 30 Days)*			
Data Element/MY	**2019**	**2020**	**2021**
Numerator	830	953	1,099
Denominator	1,736	1,820	2,147
Rate	**47.81%**	**52.36%**	**51.19%**

*PTM did not validate results for MY 2019-2020

3.4.1 Quality, Timeliness, and Access

Strengths.

- UnitedHealthcare staff was well prepared for a site review and had all claims and preparation completed ahead of schedule.
- UnitedHealthcare demonstrated and articulated its knowledge and experience of the measures under review.
- UnitedHealthcare updates its systems with the most current diagnoses and procedures as they become available during the year.
- UnitedHealthcare continues to review its source code to ensure it is error-free.
- Appropriate services, such as laboratory, primary care, and hospital access, are readily available in all regions.
- UnitedHealthcare was able to demonstrate its ability to capture the specific diagnosis.

- UnitedHealthcare continues to monitor and improve upon the data captured in both primary and supplemental data for numerator compliance for all measures, including FUH-30 days.
- UnitedHealthcare's CHL rate significantly improved from 45.27% (MY 2020) to 50.16% (MY 2021) by 4.89% points (Table 3-10).

Weakness. UnitedHealthcare's W30 rate for age cohort 15-30 months dropped significantly from 64.57% (MY 2020) to 59.29% (MY 2021) by 5.28% points. The rate drop in this age cohort may continue to be attributed to COVID-19.
Although PTM services didn't validate the FUH-30 days in the previous two years, UnitedHealthcare's FUH-30 days trended down slightly compared to MY 2020. While the trend is not considered statistically significant at -1.17% points difference year over year, it should be considered a potential issue as enrollment increases.

3.4.2 Improvement from previous year

Response to Previous Year's Recommendations. Table 3-13 describes actions taken by UnitedHealthcare in response to EQRO recommendations during the previous EQR 2021. PTM evaluated UnitedHealthcare's response and categorized it as High, Medium, and Low. (The definitions of these categories are the same as described earlier in section 2.1 of this report.)

Table 3-13. UnitedHealthcare's Response to Previous Year's Recommendations

EQRO Recommendation	Action by UnitedHealthcare	Degree of Response
PTM continues to recommend that UnitedHealthcare improve outpatient mental health services and educate the members to have a follow-up visit to a doctor within seven days and thirty days post-hospital discharge.	UnitedHealthcare should facilitate the scheduling of follow-up visits for the member. UnitedHealthcare decreased by 1.17% points from the previous year, but this was not a significant change.	**Medium** There is still room for improvement in outpatient mental health services.
UnitedHealthcare should consider incentivizing providers to meet with members for the W30 measure. This may positively impact the rates for future years.	UnitedHealthcare was not successful at increasing compliance. UnitedHealthcare's rate significantly decreased year over year by 5.28%	**Low** No improvement was noted for this measure.

	points for the 15-30 months age cohort. Though the rate increased by 4.95% points for the 0-15 months age cohort.	
PTM recommends that UnitedHealthcare continue education and outreach efforts to members and providers to increase Chlamydia screenings.	Members were outreached throughout the year and educated to seek CHL screenings. UnitedHealthcare showed a significant increase of 4.89% points in CHL screening year over year.	**Medium** There was a positive impact on outreach with members and providers.

3.5 Recommendations for MCOs

Home State Health, Healthy Blue, and UnitedHealthcare must address all recommendations from the previous years scored as "Low" and "Medium" (refer to Tables 3-5, 3-9, 3-13).

4.0 REVIEW OF COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS

4.1 Objective and Technical Method

PTM assessed Home State Health, Healthy Blue, and UnitedHealthcare's compliance with the 42 CFR 438/42 CFR 457 (7 of 14 regulations), the corresponding regulations from the MHD QIS 2021, the MHD Managed Care contract, and the progress made in achieving quality, access, and timeliness to services from the previous year's review. Table 4-1 describes all the regulations (a total of 14) that will be covered during the current review cycle (EQR 2021-2023). EQR 2022 is the second year of the review cycle.

Table 4-1. Review Cycle: EQR 2021-EQR 2023

Year	42 CFR 438 (Medicaid)	42 CFR 457 (CHIP)	Standard Name
EQR 2021 (1-year)	438.56	457.1212	Disenrollment: Requirements and limitations
	438.100	457.1220	Enrollee rights
	438.114	457.1228	Emergency and post-stabilization services
	438.230	457.1233(b)	Subcontractual relationships and delegation
	438.236	457.1233(c)	Practice guidelines
	438.242	457.1233(d)	Health information systems
EQR 2022 (2-year)	438.206	457.1230(a)	Availability of services
	438.207	457.1230(b)	Assurances of adequate capacity and services
	438.208	457.1230(c)	Coordination and continuity of care
	438.210	457.1230(d)	Coverage and authorization of services
	438.214	457.1233(a)	Provider selection
	438.224	457.1110	Confidentiality
	438.228	457.1260	Grievance and appeal system
EQR 2023 (3-year)	438.330	457.1240(b)	Quality assessment and performance improvement program

The compliance review was conducted in February-May 2022, following the guidelines from the CMS, EQR Protocol 3. The process included the following steps:

Collaboration: PTM collaborated with the MHD and the three MCOs for the following:

- To determine the scope of the review, scoring methodology, and data collection methods.
- To develop the site review (virtual meeting) agenda.
- To provide preparation instructions and expectations.
- To collect and review data/documents before, during, and after the site meeting.

- To submit deficiencies in writing following the preliminary review and site meeting.
- To compile data and information, and analyze the findings.
- To prepare a report related to the findings of the current year.
- To review the MCOs' corrective actions in response to the previous year's recommendations.

Evaluation Tools: PTM created evaluation tools based on the CFR, EQR protocol, the MHD Managed Care contract, and the QIS 2021.

Technical Assistance (TA): PTM sent the evaluation tools to the MCOs before the preliminary review, setting the expectations for the documents' submissions. The preliminary review findings and requirements were submitted to the MCOs in writing before the site meeting.

Documents' Submissions: The three MCOs uploaded their documents to the PTM's secure web-based file storage platform (AWS S3 SOC 2), enabling a complete and in-depth analysis of its compliance with the regulations. PTM reviewed policies and procedures, spreadsheets, PowerPoint presentations, reports, newsletters, mailers, templates, emails, toolkits, and print screens.

Site Interviews: PTM conducted site meetings with Home State Health, Healthy Blue, and UnitedHealthcare on May 2, May 3, and May 4, 2022, respectively. Due to the Covid-19 pandemic (public health emergency), the site meetings were conducted virtually. The interviews during the site meetings aimed to collect data to supplement and verify the findings of the preliminary document review.

Compliance Ratings

PTM analyzed the information provided by the MCOs and assigned a score for each regulation. Then an overall compliance score for all the regulations was also calculated. Two points were assigned to each section/criterion in the evaluation tool (denominator) and scored (numerator) Fully Met (two points), Partially Met (one point), or Not Met (zero points) based on the definitions from the CMS, EQR Protocol 3 (Table 4-2).

Table 4-2. Compliance Rating Scale

●	**Fully Met**: All documentation listed under a regulatory provision, or component thereof, is present. MCO staff provide responses to reviewers that are consistent with each other and with the documentation. A State-defined percentage of all data sources–either documents or MCO staff–provides evidence of compliance with regulatory provisions.

🟡	**Partially Met**: All documentation listed under a regulatory provision, or component thereof, is present, but MCO staff are unable to consistently articulate evidence of compliance; or MCO staff can describe and verify the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice; or any combination of "Met," "Partially Met" and "Not Met" determinations for smaller components of a regulatory provision would result in a "Partially Met" designation for the provision as a whole.
🔴	**Not Met**: No documentation is present, and MCO staff have little to no knowledge of processes or issues that comply with regulatory provisions; or No documentation is present, and MCO staff have little to no knowledge of processes or issues that comply with key components (as identified by the State) of a multi-component provision, regardless of compliance determinations for remaining non-key components of the provision.

The compliance score was further categorized in terms of the level of compliance (Table 4-3).

Table 4-3. Compliance Level

Compliance Level	Score%
High Compliance	90% and above
Moderate Compliance	75%-89%
Low Compliance	Less than 75%

Corrective Action Process

PTM initiated a corrective action plan (CAP) after submitting the final report to the MHD. The CAP was recommended for all weaknesses identified, including the "Not Met/Partially Met" criteria. The CAP must detail the interventions the MCOs plan to implement to comply with the regulations, including how the MCOs measure the effectiveness of the intervention, the individuals responsible, and the timelines proposed for completing the planned activities. The MCOs submitted the CAP to the MHD within 10 calendar days of its initiation. When deemed sufficient, the MHD, in consultation with PTM, approved the CAPs on Oct 7, 2022. Within 90 calendar days of CAP approval (due on Jan 5, 2023), the MCOs must submit their documentation to close the identified gaps.

4.2 Findings, Analysis, Conclusions, and Recommendations: Home State Health

EQR 2022 assessed seven federal regulations, with Home State Health achieving a compliance score of 90.9%. Table 4-4 summarizes findings from the first (EQR 2021) and second year (EQR 2022) of the current three-year review cycle (EQR 2021-2023).

Table 4-4. Compliance Summary for EQR 2021-2022

		Number of Sections						
42 CFR 438/457	Medicaid/CHIP Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Confidence Level
438.206 457.1230(a)	Availability of services	10	8	2	0	18	90	High
438.207 457.1230(b)	Assurances of adequate capacity and services	14	9	5	0	23	82.1	Moderate
438.208 457.1230(c)	Coordination and continuity of care	19	19	0	0	38	100	High
438.210 1230(d)	Coverage and authorization of services	19	17	2	0	36	94.7	High
438.214 457.1233(a)	Provider selection	14	12	2	0	26	92.9	High
438.224 457.1110	Confidentiality	22	20	1	1	41	93.2	High
438.228 457.1260	Grievance and appeal system	34	24	10	0	58	85.3	Moderate
Overall Result EQR 2022 (2-Year)		**132**				**240**	**90.9**	**High**
438.56 457.1212	Disenrollment: Requirements and limitations	18	16	2	0	34	94.4	High
438.100 457.1220	Enrollee rights	18	11	6	1	28	77.8	Moderate
438.114 457.1228	Emergency and post-stabilization services	12	12	0	0	24	100	High
438.230 457.1233(b)	Subcontractual relationships and delegation	12	10	2	0	22	91.7	High
438.236 457.1233(c)	Practice guidelines	06	06	0	0	12	100	High
438.242 457.1233(d)	Health information systems	16	14	2	0	30	93.8	High
Overall Result EQR 2021 (1-Year)		**82**				**150**	**91.5**	**High**

Compliance Score % = $\frac{\text{Total Score X100}}{\text{Total Sections X 2 points}}$

4.2.1 Quality, Timeliness, and Access

Home State Health's strengths and weaknesses in the healthcare services in the domain of Quality, Timeliness, and Access to Care are summarized as follows.

Regulation I- Availability of Services.

Strengths.

a. Home State Health complies with the geographic distribution (distance travel)

standards and the appointment standards required by the MHD for all enrollees, including those with limited English proficiency or physical or mental disabilities. The services included in the contract are available 24 hours a day, seven days a week, when medically necessary. Home State Health analyzes its network adequacy monthly by running Geo Access Maps for all contracted network providers. During the interview, the staff was knowledgeable about the geographical access reporting system Home State Health utilized to track the provider-member ratio and geographic distribution of providers and members. **(Timeliness, Access to Care)**

b. Home State Health disseminates the appointment and after-hours standard requirements to its in-network providers and members via Home State Health's provider orientation presentation, provider reference manual, at least annually in the provider and member newsletters, member handbook, and ongoing provider education materials. **(Timeliness)**

c. Home State Health monitors compliance with appointment and after-hours standards and will have a CAP when appointment and after-hours standards are not met. Calls from Home State Health's contracted vendor verify the contracted providers' appointment availability and confirm whether the provider's panel is open or closed. Phantom after-hours calls by the contracted vendor are made to monitor whether the provider has adequate 24/7 service availability. **(Quality)**

d. Authorization for a second opinion is granted to a network provider (or an out-of-network provider if there is no in-network provider available) when there is a question concerning diagnosis, options for surgery, or other treatment of a health condition, or when requested by any representative of the member's health care team, the member, or a parent/guardian(s). **(Access to Care)**

e. Home State Health provides for the availability of transfer protocols and arrangements with out-of-network providers for services that are not available from a qualified in-network practitioner. **(Access to Care)**

f. The providers are encouraged to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care. During the interview, Home State Health described measures taken to help members with limited English proficiency and low literacy: care managers explain written materials to the members; educational videos are posted on the website; the KRAM library is utilized for member education; call center staff is educated and trained using Empathy Tools; and member services connect directly with provider offices for translation services if needed. **(Quality)**

g. The provider network operations, contracting and network development, and provider relations departments select and recruit the providers to the network by regularly monitoring and considering various factors, including whether the location provides physical access for members with disabilities. Home State Health will provide accommodation, if needed, to ensure all members have equal access to 24 hours per day health care coverage. **(Access to Care)**

h. Female members may self-refer to an OB/GYN for routine women's health services regardless of whether the PCP (general practitioner, family practitioner, or internist) provides such women's health services, including routine gynecological exams. **(Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-5.

Table 4-5. Availability of Services

Weakness	EQRO Recommendation
a. The policy, "Provider Appointment and Accessibility Standards," does not include behavioral health providers for all appointment-related standards.	Update policy, "Provider Appointment and Accessibility Standards," to include behavioral health providers for the appointment availability standards.
b. None of the policies addressed the requirement of ensuring that the network providers offer hours of operation that are no less than those offered to commercial enrollees or comparable to Medicaid FFS.	The policy should incorporate the requirement and describe the process for ensuring no discrimination related to the work hours of Medicaid enrollees.
c. The policies partially addressed the contractual requirements regarding Access and Cultural consideration per the MHD contract, section 2.3.1.	Update policies to include: • Strategies to recruit, retain, and promote diverse staff and leadership that are representative of the demographic characteristics of regions covered by the contract at all levels of the organization. • Provision of member materials in their preferred language, verbal offers, and written notices when required, informing them of their right to receive language assistance services. • The MCO shall develop participatory, collaborative partnerships with communities and utilize a variety of

	formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services in health care. • Make information available to the public about the MCO's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.

Regulation II- Assurances of Adequate Capacity and Services.

Strengths.

a. Home State Health's provider network consists of hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, safety-net hospitals, and all other provider types necessary to ensure sufficient capacity, in accordance with the accessibility service standards consistent with State requirements. **(Access to Care)**

b. The provider network includes a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults, including Community Mental Health Centers (CMHCs) and Community Behavioral Health Organizations (CCBHOs). Home State Health has contracted with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Local Public Health Agencies, Tertiary Care centers (trauma centers, burn centers, stroke centers, high-risk nurseries, cardiac hospitals), pediatric hospitals, family planning, and sexually transmitted disease treatment providers and dentists providing school-based dental services. **(Access to Care)**

c. Home State Health received an "Approved" status for its Annual Access Plan 2021 from the Department of Commerce and Insurance. The plan describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues. (Note: PTM did not review the Access Plan as the Network Adequacy assessment is out of scope for EQRO and currently carried out by the State.) **(Access to Care)**

d. The MHD is notified of any change in the provider network or Home State Health's operations that would affect the adequacy of capacity, services, benefits, and geographic

service areas within five business days of identification of the issue. **(Timeliness, Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-6.

Table 4-6. Assurances of Adequate Capacity and Services

Weakness	EQRO Recommendation
a. A policy describing the responsibilities of a PCP as per the MHD contract, section 2.4.2(a), was not submitted.	Develop a policy to include the responsibilities of PCPs.
b. A policy for eligible providers serving as PCPs in institutions with teaching programs was unavailable during the review period. Home State Health revised its policy, "Utilizing the Specialist as the PCP," after PTM identified the deficiency.	Submits the revised policy, "Utilizing the Specialist as the PCP," for the MHD's approval.
c. The member handbook does not include information on freedom of choice for family planning services.	Update member handbook
d. The Single Case Agreement template for out-of-network providers has information on care coordination and billing procedures but does not include information on medical record management.	Update the Single Case Agreement template for out-of-network providers.
e. A policy to include contracting and reimbursing dental providers for services in the school setting was not submitted. However, the policy, "Network Adequacy," was revised to incorporate school-based dental services after PTM identified the deficiency.	Submit the revised policy, "Network Adequacy," for the MHD's approval.
f. Home State Health did not address the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). Home State Health informed PTM that there are no Indian Reservations in	Address requirements related to American Indian/Alaskan Natives per the MHD contract 2.4.18.

Missouri. However, Home State Health's Provider Reference Manual states that Home State Health's American Indian/Alaskan Natives have a right to receive care from Indian Health Care Providers (IHCP).	

Regulation III- Coordination and Continuity of Care

Strengths.

a. Due to Home State Health's processes of PCP auto-assignment, there are no barriers to members receiving access to care in or out of the Home State Health's provider network upon entry into Home State Health. **(Access to Care)**

b. Home State Health begins Welcome Calls upon a member's enrollment and is completed within the first 90 days in accordance with state or federal contract. The outreach staff conducts a brief Health Risk Screening (HRS) to identify whether the member is pregnant, has a chronic condition, and has special health care needs. **(Quality)**

c. Home State Health has policies and procedures that address the transition of care requirements for newly enrolled members from other MCOs or Fee-For-Service (FFS) programs. **(Quality, Timeliness)**

d. Relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if Home State Health changes subcontractors. **(Timeliness)**

e. Home State Health coordinates with out-of-network providers and the previous MCO to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with physical health or behavioral health provider who is not in Home State Health's network. Home State Health will facilitate securing a member's records from the out-of-network providers as needed and pay rates comparable to FFS for these records unless otherwise negotiated. **(Quality, Timeliness)**

f. Home State Health facilitates continuity of care for medically necessary covered services and is responsible for the costs of continuing such services without prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. The services will continue for the lesser of 60 calendar days or until the member has transferred to an in-network provider without disrupting care. **(Quality, Timeliness, Access to Care)**

g. Members in the third trimester of pregnancy will continue to receive services from their prenatal care provider (whether in-network or out-of-network), without prior authorization, through the postpartum period (defined as 60 calendar days from the date of birth). All pregnant members will continue to receive services from their behavioral health treatment provider without prior authorization until the birth of the child, the cessation of pregnancy, or loss of eligibility. **(Timeliness)**

h. Home State Health does not require prior authorization during the transition of care for inpatient and residential treatment days is not required. **(Timeliness, Access to Care)**

i. Home State Health's Integrated Care Team (ICT) will facilitate communication and coordination between the PCPs and specialists, including behavioral health providers, Federally Qualified Health Centers, and Rural Health Clinics, to ensure continuity of care and prevent duplication of services. **(Quality)**

j. For all uses and disclosures of a member's protected health information (PHI), Home State Health will obtain a signed authorization from the member unless the use or disclosure is required or otherwise permitted without authorization by 45 CFR Part 164 Subparts A and E (the Privacy Rule). **(Quality)**

k. Home State Health includes Section 2703 designated health home treating physician, clinical practice, or advance practice nurse in their provider network for members in a Section 2703 designated health home if the provider meets Home State Health's minimum credentialing standards. **(Quality, Access to Care)**

l. Home State Health has policies and procedures that address the requirements of the Hospital Care Transition (HCT) program to integrate with and enhance the discharge planning and care transition activities of the hospital as required by the CMS. Home State Health coordinates the services to the enrollees between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. **(Quality)**

m. Home State Health provides services for enrollees with special health care needs. Members are identified for care management through several data sources, e.g., claims and encounter data, predictive modeling software, hospital discharge data, and State enrollments. An assessment for care management is completed within 30 days of enrollment for new members with a diagnosis that needs complex care management/care management. The care plan is developed in conjunction with the member, the member's authorized representative or guardian, authorized family members, the managing physician, and other members of the health care team. Behavioral health care coordination

is incorporated into the care plan as needed. The care plan is created utilizing clinical practice guidelines (including the use of CyberAccess™ to monitor and improve medication adherence and prescribing practices consistent with practice guidelines). **(Quality, Access to Care)**

n. Members may have a standing referral from a specialist if they have a condition that requires ongoing care from a specialist. In cases where services cannot be reasonably obtained by a network provider, services can be rendered by an out-of-network provider if the services are medically necessary, a covered benefit, and authorized by Home State Health. **(Access to Care)**

Weaknesses and Recommendations. No areas of concern were identified pertaining to the criteria evaluated for this regulation. However, PTM identified a weakness in the submitted documents, as stated in Table 4-7.

Table 4-7. Coordination and Continuity of Care

Weakness	EQRO Recommendation
The policy, "Medical Record Review," and the provider manual state that the practitioners must maintain all member records for at least seven years from the last professional service provided.	Update the medical record retention period to 10 years per 42 CFR 438.3u.

Regulation IV- Coverage and Authorization of Services.

Strengths.

a. Home State Health provides covered services sufficient in amount, duration, and scope to reasonably achieve their purpose and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. The services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same series furnished to beneficiaries under FFS Medicaid. **(Access to Care)**

b. Home State Health's coverage of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called Healthy Children and Youth-HCY program in Missouri) to all members under the age of 21 years in compliance with the terms of the MHD contract and the federal government to identify health and developmental problems. These services are sufficient in amount, duration, and scope to reasonably achieve their purpose and will only be limited by medical necessity. **(Access to Care)**

c. Home State Health covers family planning services by any qualified provider, whether the provider is in-network without referral/authorization. Home State Health allows full freedom of choice to provide these services. **(Access to Care)**

d. Home State Health does not require prior authorization for emergency medical and behavioral health services, involuntary detentions (96-hour detentions or court-ordered detentions), or commitments for any inpatient days while the court order or commitment is in effect. **(Timeliness, Access to Care)**

e. Home State Health complies with the Wellstone–Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), as applicable to the Medicaid MCOs. Home State Health will ensure that any benefit limitations for mental health or substance use disorder (MH/SUD) benefits are comparable to those for medical/surgical benefits and will not impose less favorable benefit limitations on MH/SUD benefits compared to medical/surgical benefits, including annual and lifetime dollar limits, financial requirements, or treatment limitations**. (Quality)**

f. Home State Health assists members in making necessary arrangements to fulfill prior authorization requirements. If such arrangements cannot be made timely, the requested services will be approved. **(Quality, Timeliness)**

g. A decision to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and support needs. A Medical Director or qualified designee reviews all appeals and denials. **(Quality)**

i. Home State Health ensures an interim supply of an item is available during the authorization process. Member's treatment regimens are not interrupted or delayed (e.g., physical, occupational, and speech therapy; psychological counseling; home health services; personal care) by the prior authorization process. Payment of custom items (e.g., custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) delivered or placed within six months of approval are made even if the member's enrollment ends. **(Access to Care)**

j. Home State Health will not deny the physician's request for continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Home State Health and scheduled within seven days of discharge that meets the medical needs of the member. **(Timeliness, Access to Care)**

k. Home State Health complies with the timeframes for prior authorization decisions for non-emergency services as determined by emergency room staff (30 minutes), urgent services (24 hours), and standard services within 36 hours of service request. Home State Health notifies the requesting provider and gives the enrollee written notice of any decision by Home State Health to deny a service authorization request or authorize service in an amount, duration, or scope that is less than requested. **(Timeliness)**

l. All individuals making Utilization Management (UM) decisions at Home State Health sign an 'Affirmative Statement about Incentives,' acknowledging that the organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care and that Home State Health does not offer financial incentives for UM decisions that result in underutilization. **(Quality)**

m. During the interview, Home State Health reported about its emergency backup plan for its members in the event of a disaster. Simulation exercises are undertaken throughout the year per the business continuity disaster plan. Mass texting and emails are sent to the providers. **(Quality, Timeliness, Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-8.

Table 4-8. Coverage and Authorization of Services

Weakness	EQRO Recommendation
a. Documentation on the criterion that Home State Health will not arbitrarily deny or reduce the amount, duration, or scope of a required service to an otherwise eligible beneficiary solely because the diagnosis, type of illness, or condition, was not submitted.	Submit documentation to comply with the requirement.
b. "Clinical Policy-Medical Necessity Criteria" does not comply with the definition of Medical Necessity.	Update policy.
c. Home State Health shall not subsequently retract its authorization, revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider, after services have been provided, or reduce payment for an item or	The time limit of 45 days is stated in the policy, "Timeliness of UM Decisions and Notifications." However, there is no time limit set in the MHD contract. Therefore, PTM recommends that Home State Health clarify the time limit of 45 days with the MHD.

service (except under some circumstances-misinterpretation or omission of health information, contract termination, coverage termination).	
d. Provider reference manual states that emergency room and post-stabilization services never require prior authorization, whereas Home State Health's policy, "Timeliness of UM Decisions and Notifications," requires an authorization determination within 60 minutes of receiving post-stabilization services. Furthermore, PTM noted that the response timeframe to the post-stabilization service request in 60 minutes is also incorrect.	Update the provider reference manual and the policy, "Timeliness of UM Decisions and Notifications," with a correct timeframe for authorization decisions on post-stabilization services.

Regulation V- Provider Selection.

Strengths.

a. Credentialing and re-credentialing policies and procedures comply with the requirements of determining and assuring all in-network providers are licensed by the state where they practice and are qualified to perform their services. Home State Health has a policy and procedure to monitor practitioner sanctions, exclusions, complaints, and quality issues between re-credentialing cycles to maintain a network of participating practitioners who meet or exceed the standards for delivering high-quality, safe care to members. Home State Health utilizes Council for Affordable Quality Health Care (CAHQ) Universal Credentialing Data Source Form (UCDS) as the credentialing application for all practitioner credentialing in compliance with the MHD contract, section 2.18.8(c). **(Quality)**

b. The average turnaround time for credentialing reported by Home State Health in CY 2021 is 19 calendar days (the timeframe set by the MHD is 60 business days). **(Timeliness)**

c. Home State Health assesses the providers' medical record-keeping practices against the established standards. As part of re-credentialing, Home State Health reviews a sample of records from PCPs, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives. The elements scoring below 80% are considered deficient and need improvement. **(Quality)**

d. Home State Health's Provider Agreement requires a provider to agree to furnish with complete and accurate information necessary to permit Home State Health to comply with the collection of disclosure requirements specified in 42 CFR Part 455, Subpart B, or any other applicable state or federal requirements. Home State Health requires all its subcontractors to make disclosures to Home State Health of complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicaid: 1) upon execution of the subcontract; 2) within 35 calendar days of any change in ownership; and 3) at any time upon request by Home State Health and the State for any or all such information. **(Quality, Timeliness)**

e. Home State Health notifies the MHD of any denial of provider credentialing or re-credentialing on time. It will report provider terminations as part of its quarterly fraud and abuse report per the State provided forms. **(Quality, Timeliness)**

f. Home State Health shall exclude providers from participation who have been identified as having a non-renewed license or certification registration, has a revoked professional license or certification, or have been terminated by the state agency. Home State Health will access information from the Professional Registration Boards Internet site to identify State initiated terminations. The List of Excluded Individuals/Entities (LEIE) will be queried through the Office of Inspector General's (OIG) website. **(Quality)**

g. Data for the newly credentialed hospitals and facilities attached to a new or existing contract is loaded in the claims adjudication and payment system at the same time when credentialing is completed. The practitioner's par affiliation start date is the date on which the practitioner is eligible to submit a claim and receive contracted rates. It is not dependent upon the completion of credentialing. **(Timeliness)**

h. Home State Health is committed to providing equal employment opportunities for all applicants and employees in all employment decisions. Provider and contracted providers recognize that, as a governmental contractor, company or payor may be subject to various federal laws, executive orders, and regulations regarding equal opportunity and affirmative action, which also may apply to subcontractors. Provider and each contracted provider agree to comply with such requirements described in the Participating Provider Agreement. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-9.

Table 4-9. Provider Selection

Weakness	EQRO Recommendation
a. The list of providers in the policy, "Practitioner Credentialing and Recredentialing," does not include provisionally licensed psychologists and provisionally licensed professional counselors.	PTM recommends that Home State Health updates its documentation and ensures its credentialing process includes provisionally licensed psychologists and professional counselors in the provider network.
b. Documentation about minority inclusion and dissemination of information to its subcontractors was not submitted. The participating provider agreement does not specify the requirement.	Submit documentation about minority inclusion and dissemination of information to its subcontractors.

Regulation VI- Confidentiality.

Strengths.

a. Employees are prohibited from any unauthorized access to, use, or disclosure of patient or health care provider information, Home State Health's proprietary information, including but not limited to medical records, claims, benefits, or other administrative data that is personally identifiable, in addition to quality improvement programs, reports, and disease management information. No member information shall be released to the public without the prior written consent of the MHD. **(Quality)**

b. All employees, contractors, and designated contingent workers who are granted Home State Health information system and network access credentials must complete security training in accordance with established organization security training requirements. The users must complete training requirements within 30 days of receiving information system and network access credentials and at least annually. HIPAA privacy program sets the standards for employees in safeguarding confidential and PHI in any format: electronic, paper, or verbal. **(Quality)**

c. Home State Health may not use or disclose members' identifiable Part 2 records to any third party, including the member's PCP or family members, unless Home State Health has received a Part 2 compliant Authorization to Use and Disclose Health Information form from the member, or their legal guardian or representative. **(Quality)**

d. Home State Health may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1) (Disclosures by whistleblowers and

workforce member crime victims). It shall notify the state agency no later than 10 calendar days after Home State Health becomes aware of the disclosure of the PHI. **(Quality, Timeliness)**

e. Use and Disclosure of PHI are permitted without authorization only for treatment, payment, and day-to-day Healthcare operations. Home State Health may disclose PHI without member authorization in compliance with and as limited by the relevant requirements of a court order, court-ordered warrant, subpoena, or summons issued by a judicial officer or a grand jury subpoena. **(Quality)**

f. Home State Health may use PHI to provide data aggregation services to the MHD. Home State Health may not use PHI to de-identify or re-identify the information in accordance with 45 CFR 164.514(a)-(c) without specific written permission from the MHD to do so. **(Quality)**

g. When using or disclosing PHI or requesting PHI from a third party, Home State Health employees shall make reasonable efforts to limit the PHI used, disclosed, or requested to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. **(Quality)**

h. Home State Health will execute a Business Associate Agreement (BAA) that complies with 45 CFR 164.504(e) with any entity that creates, receives, maintains, or transmits PHI on behalf of Home State Health. The business associate contracted with Home State Health must agree to the same restrictions and conditions that apply to Home State Health for such information. **(Quality)**

i. The business associate will make its internal practices, books, and records available to the Covered Entity, the Secretary, or the state agency and complete any written attestation within 10 calendar days of a written request. **(Timeliness)**

j. Home State Health shall provide an accounting of disclosures of PHI regarding an individual; and the access to the PHI in an individual's designated record set to the MHD by no later than five calendar days of the request. **(Timeliness)**

k. Home State Health and its subcontractors will report any incident (security incident, unauthorized use or disclosure of PHI not permitted or required, breach of PHI, or loss, destruction, alteration, or other events in which PHI cannot be accounted for) within five days of discovering the incident. **(Timeliness)**

l. The Privacy Officer will maintain HIPAA-required documentation, in written or

electronic form, of policies, procedures, communications, and other administrative documents for additional years than required by 45 CFR 164.530 (i) and (j), for a period of at least 10 years from the date of creation or the date when last in effect, whichever is later. **(Timeliness)**

m. Prior to any use or disclosure of PHI for marketing, Home State Health will obtain authorization from the member. If the marketing involves financial remuneration to Home State Health from a third party, the authorization must state that such remuneration is involved. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-10.

Table 4-10. Confidentiality

Weakness	EQRO Recommendation
a. Written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services, were not submitted.	Submit documentation.
b. Documentation to show that Home State Health shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s), or subcontractor(s), was not available during the review period. A new policy, "MO HealthNet Business Associate Provision Requirements," was developed after the preliminary review.	Submit the new policy, "HealthNet Business Associate Provision Requirements," for the MHD's approval.

Regulation VII- Grievance and Appeal System.

Strengths.

a. Home State Health maintains procedures for the receipt and prompts internal resolution of all grievances, appeals, and State Fair Hearing processes that comply with all applicable state and federal requirements and accreditation standards. Home State Health

refers all members who are dissatisfied with Home State Health or its subcontractors in any respect to contact the Member Services Department. When applicable, the expression of dissatisfaction is forwarded to Home State Health's grievance and appeals coordinator (GAC) to review. **(Quality)**

b. Oral inquiries seeking to appeal an adverse determination are treated as appeals (to establish the earliest possible filing date for the appeal). **(Quality, Timeliness)**

c. Home State Health has policies and procedures to comply with the timeframe of filing a grievance (any time), an appeal (within 60 calendar days of adverse benefit determination notice), and a State Fair Hearing (within 120 calendar days of notice of resolution of an appeal), timings of notice of adverse benefit determination, acknowledgment of receipt of each grievance and appeal in writing (within 10 business days after receiving a grievance or appeal) and timely filing (within 10 calendar days of notification) for the continuation of benefits when an appeal or State Fair Hearing is pending. **(Timeliness)**

d. Enrollees are provided any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. The assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability. **(Quality)**

e. The member and the member's representative may request the member's case file free of charge, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Home State Health in connection with the appeal of the adverse benefit determination. **(Quality)**

f. Home State Health complies with the timeframe for resolution of grievance (30 calendar days), appeal (30 calendar days), expedited resolution for appeal (72 hours), and an extension of the timeframe for appeals (not more than 14 calendar days), and notice to the affected parties. Home State Health does not take punitive or retaliatory actions against a member or provider supporting a member for filing an expedited appeal. **(Quality, Timeliness)**

g. Home State Health is knowledgeable of its role after the final resolution of the appeal or State Fair Hearing. If the decision is against the enrollee, Home State Health may recover the cost of services furnished to the enrollee for the period appeal or State Fair Hearing was pending. Home State Health must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the adverse benefit determination. **(Quality,**

Timeliness)

h. During the interview, Home State Health reported that the grievances filed in CY 2021 were < 1% per 1000 members, and appeals were 0.03 per 1000 members, which was within their target. All appeals were resolved within the timeframe. **(Timeliness)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-11.

Table 4-11. Grievance and Appeal System

Weakness	EQRO Recommendation
a. The policy, "Adverse Determination (Denial) Notices," provider manual, and the member handbook does not accurately define adverse benefit determination.	Update the definition of adverse benefit determination in all documents.
b. The policy, "Member Grievance and Appeals System Description," states that appeal rights may not be applicable for some grievances (e.g., member grievances about Emergency Room wait times, staff conduct, or physician conduct, where there is no adverse decision to appeal). PTM remarked that there is no appeal process for grievances per the CFR/MHD contract.	Update policy.
c. The member flyer explaining the grievance and appeal process has incomplete information: State Fair Hearing in case of deemed exhaustion of appeal process is missing, and the date of approval by the MHD on the flyer is not indicated.	Update flyer
d. An exception that a provider cannot file for a continuation of benefit is not stated in the policy "Member Grievance and Appeals System Description."	Update the policy.
e. The policy, "Member Grievance and Appeals System Description," states that a member, the member's authorized representative, or a provider with the member's written consent may request a State Fair Hearing after Home State	Update policy.

Health's internal grievance, or the appeal process has been exhausted. PTM noted that Home State Health has erroneously provided an option of a State Fair Hearing for a grievance.	
f. Provider manual does not mention: • A provider can file an appeal on behalf of the member with their written consent. • Home State Health's assistance to providers in case of filing an appeal and State Fair Hearing on behalf of members. The provider manual inaccurately mentions: • Appeals must be requested orally or in writing by the member or the member's representative within 120 days of the Home State Health's notice of resolution of the appeal unless an acceptable reason for delay exists. (Home State Health has erroneously stated "appeals" instead of "State Fair Hearing.") • The term "notice of action" is used instead of "notice of adverse benefit determination." • A copy of verbal complaint logs and disposition or written grievances records shall be retained for seven years. (PTM remarked that the record retention duration should be 10 years).	Update provider manual.
g. The policy, "Member Grievance and Appeals System Description," states that if Home State Health fails to adhere to the notice and timing requirements under section 2.12.16 c(22) of the MHD contract, the member is deemed to have exhausted Home State Health's internal level of appeal and may initiate a State Fair Hearing.	Update policy.

PTM advised that the MHD contract, section 2.12.16c(22), does not mention the timeframe requirements for an appeal.	
h. The member handbook does not mention filing of a State Fair Hearing when the Home State Health does not meet the timeframe for an appeal resolution. This information is not provided in the Acknowledgement of the Appeal.	Update member handbook and letter used for acknowledgment of an appeal.
i. An oral appeal must be followed by a written request in the member handbook, and the provider reference manual is incorrect.	Update the member handbook and provider manual to reflect the correct procedure for filing an appeal.
j. The Notice of Adverse Benefit Determination has information on scheduling a peer-to-peer call allowing the treating practitioners to discuss any medical or behavioral health UM decisions with the Medical Director of Home State Health within two business days of this notification. PTM noted that the peer-to-peer call is not in compliance with 42 CFR 438.404, where there is a provision for filing an appeal after an adverse benefit notification is sent to a member instead of initiating a discussion between the treating provider and Home State Health after the notice. PTM advised that a peer-to-peer discussion should be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination.	Update the procedure in Notice of Adverse Benefit Determination consistent with the information in two policies, "Member Grievance and Appeals System Description, and "Adverse Determination (Denial) Notices."
k. If additional clinical information is received with an appeal request and meets the criteria for coverage, the practitioner who made the initial adverse determination may review the case and overturn the previous decision.	Update documentation and procedure on who should make decisions after an appeal is filed.

PTM noted that Home State Health allows the same professional who made the initial adverse determination to review the additional documents if any after an appeal is filed. This does not comply with CFR 438.406(b): those who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual should decide on an appeal or grievance.	
l. The policy, "Member Grievance and Appeals System Description," incorrectly mentions the provision of an appeal after a notice of resolution to appeal is provided to a member (one-level appeal only).	Update policy.
m. The following inaccuracies were noted in the document "Out-of-Network Provider Information:" • "Adverse action" is used instead of "adverse benefit determination." • Appeal: The review may be requested in writing or orally. However, oral requests must be followed up in writing unless an expedited resolution is requested.	Update document.

4.2.2 Improvement from previous year

Table 14-12 shows the degree to which Home State Health responded to PTM's recommendations from the previous year's EQR. PTM reviewed the documents to assess the non-compliant criteria per the CAP and the weaknesses identified in EQR 2021 (Table 4-13). Each item was assigned two points (denominator), and the response was evaluated and categorized (numerator) as follows:

- High (Two points): MCO fully addressed the recommendation, complied with the requirement, and the item is closed. (Overall score > 90%)
- Medium (One point): MCO partially addressed the recommendation, the same recommendation applies, or a new recommendation is provided, and the item remains open. (Overall score 75-89%).
- Low: (Zero points) Minimal action/no action was taken, the same recommendation applies, and the item remains open. (Overall score <75%).

Table 4-12. Score for Degree of Response						
Total	High	=	16	×2	=	32
	Medium	=	4	×1	=	4
	Low	=	3	×0	=	0
Numerator	Score Obtained					36
Denominator	Total Sections	=	23	×2	=	46
Overall Score= Medium						**78.2%**

Table 4-13. Home State Health's Response to Previous Recommendations

Recommendations	Action by Home State Health	Degree of Response
EQR 2021		
1. Disenrollment: Requirements and Limitations		
a. Home State Health updates its policy, MO.ELIG.02 Disenrollment, and implement the member's right to request disenrollment if Home State Health does not cover services the member seeks because of moral or religious objections.	Town Hall Meeting (Sept 14, 2021) MO.ELIG.02 Disenrollment: page 2	**High** Home State Health educated its employees on the requirement not to deny services regarding any moral or religious objections during the Home State Health Town Hall meeting on Sept 14, 2021. The policy was also updated.
b. Home State Health should specify in their policy, MO.ELIG.01 Eligibility Guidelines that Fee-For-Service members will remain in Fee-For-Service until an appropriate acute inpatient hospital discharge.	Town Hall Meeting (Sept 14, 2021) MO.ELIG.01 Eligibility Guidelines: page 3	**Medium** Home State Health educated its employees regarding the requirements related to hospitalization at the time of enrollment during the Home State Health Town Hall meeting on Sept 14, 2021. However, the update in the policy, "Eligibility Guidelines," does not comply with the requirement.
2. Enrollee Rights		
a. During the interview, Home State Health reported that they do not monitor whether their providers explain various treatment options to the members. EQRO suggested that Home	CAHPS Survey Report 2021 (Medicaid Child): pages-10, 13	**High** The score on question 20 in CAHPS-Doctor informed about care was 93.2% (93rd percentile), and question

State Health educate their providers regarding the provision in the CFR about providing treatment options to their members. Additionally, Home State Health can conduct member surveys internally to seek information from the members regarding various treatment options offered by the treating doctor.		12-Doctor explained things was 96.2% (66th percentile) as estimated by the Home State Health's vendor.
b. Home State Health must have a policy based on 42 CFR 438.10 for disseminating member information. There is no requirement for taglines to be in font size 18, per CFR, effective Dec 14, 2020. Home State Health should update its policy to reflect this change after discussing with the MHD for amending their contract.	Town Hall Meeting (Sept 14, 2021) MO.MBRS.06 Member Handbook and ID Cards: page 5 Member Handbook: page 48 The information on Auxiliary aids and services will be made available upon request at no cost. Home State Health educated its employees regarding the requirements related to requests for materials in an alternative format during the Home State Health Town Hall meeting on Sept 14, 2021.	**Medium** Home State Health has not submitted its policy, "Marketing Member-Facing Material Submission to the MHD," to show if the requirement for the font size 18 is updated. PTM recommends that the taglines not be in font 18 in the member materials per the CFR.
c. Home State Health update their policy, MO.MBRS.06 Member Handbook and ID Cards based on the MHD contract section 2.12.16.	MO.MBRS.06 Member Handbook and ID Cards: page 4	**High**
d. Home State Health should have a policy/procedure of notifying their enrollees of any significant change in the member handbook at least 30 calendar days before the intended effective date of the change. Supporting evidence (mail letters, newsletters) should be submitted.	MO.MBRS.06 Member Handbook and ID Cards: page 5 Home State Health reported no significant updates or changes to the	**High** PTM visited the Home State Health website and found the information about AEG and the member handbook 2022 (page 15).

	member handbook during 2021.	PTM noted that the staff was unaware of any significant change to the member handbook. PTM recommends that the staff be updated when significant changes are made and know the regulations and how to address the requirements.
e. Home State Health updates its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.	Member Handbook 2022: page 48	**Low** Home State Health informed PTM about their changes to the member handbook-July 2021 version. However, PTM downloaded the most recent 2022 version on their website and noted the findings (see notes below).

Findings: Out of 48 criteria required in the member handbook, per the MHD contract 2.12.16, seven were "Partially Met," and one was "Not Met" during EQR 2021. PTM re-reviewed the revised member handbook 2022 available at Home State Health's website and found that only one of seven "Partially Met" criteria were addressed. Thus, six criteria remain "Partially Met," and one remains "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows:

i. The information on where and how members may access benefits not available under the comprehensive benefits package is not presented in the member handbook for all the services.

J. The definition of medical necessity used in determining whether benefits will be covered should be updated according to the MHD contract.

t. The information on the member's right to disenroll with or without cause is incomplete.

v. The timeframe for filing a grievance is not written.

a.18. The MHD provides the language for Advance Directives as a template. Home State did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience," as required in the MHD contract. During the interview, Home State Health informed EQRO that they impose no limitations.

a19. A description of the additional information available upon request and information on Home State Health structure is missing.

a.22. Home State Health must inform members how they can obtain information from the state agency about accessing the services MCO does not cover because of moral or religious objections not mentioned in the member handbook. There is one criterion (q), which is scored as "Not Met" in the member handbook: How a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and how such access may be obtained.		
f. Home State Health updates its policy, "MO.PRVR.19 Provider Directory Updates," to include all the requirements about their network providers. The provider directory (PDF version) submitted to Primaris (PTM) should be updated to consistently reflect all the criteria for every provider and hospital in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. Home State Health should educate its providers about the contractual requirement for submitting their information to Home State Health.	MO.PRVR.19 Provider Directory Updates: page 1 Provider Directory-Central MO (PDF-10/19/21)	**High** Information on the panel, linguistic capabilities, availability of sign language services, and URLs (as applicable) are not available for all hospitals and physicians in the PDF version. Icons/abbreviations used for physicians are not explained (e.g., B, CT) in the provider directory (PDF). However, all the required elements are addressed on the website search tool for the providers. PTM recommends that Home State Health continues its efforts to capture all the information required per the MHD contract/CFR for all its network providers.
g. Home State Health uploads its provider directory on its website in a machine-readable format (computer/mobile readable). Thus, the members will have access to them once downloaded on their computer or mobile, even without internet accessibility/availability.	https://www.homestatehealth.com/find-a-doctor/find-a-provider-guide.html Email communication	**High** PTM noted sufficient evidence in support of compliance with this section.
3. Emergency and Post-stabilization Services		

Home State Health must update their Participating Provider Agreement for Medicaid with medical records retention to 10 years from the last date of the contract period or from the date of completion of any audit, whichever is later (ref. 42 CFR 438.230).	Business Associate Agreement (Revised Template 2021-04.1): page 6 Participating Provider Agreement (Revised Sample): page 23 Home State Health updated the documents with accurate information.	**High**
4. Subcontractual Relationships and Delegation		
a. Home State Health explicitly includes language regarding "legal and financial aspects" of their responsibility/accountability in their policy. Also, Home State Health must incorporate it in the subcontract with TurningPoint Healthcare Solutions and all other subcontracted vendors.	Amendment 1 to Addendum 8 (Turning Point)	**High** The subcontractor (Turning Point) agreement is updated. PTM recommends that Home State Health uses the revised template (as applicable) for all the other subcontractors.
b. Home State Health has a policy/procedure regarding establishing new subcontracting arrangements or changing subcontractors. The MHD's approval is required before any subcontract is effective.	MO.COMP.21 Oversight of Delegated Vendors: page 1	**High**
c. Home State Health update their policy, MO.COMP.21 Oversight of Delegated Vendor, to require its providers to maintain the records for a minimum of 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.	MO.COMP.21 Oversight of Delegated Vendors: page 2	**High**
5. Practice Guidelines		
a. Home State Health must update the immunization schedule posted on its website with the most current version.	https://www.homestatehealth.com/members/medicaid/health-	**High**

	management/get-vaccinated.html	
b. Home State Health follows its policy regarding informing its members about the practice guidelines. The information about practice guidelines and the member's right to request these may be disseminated via the member handbook, newsletters, mailers, and website. Currently, the care managers at Home State Health inform the members enrolled in the care management program about the availability of these guidelines.	Home State Health did not submit any documentation.	**Medium** PTM visited Home State Health's website and found Krames Online patient education resource, which is an extensive library of evidence-based, peer-reviewed information written specifically for patients and covers diseases and conditions, diagnoses and treatments, surgeries and procedures, and wellness and safety for people of all ages and walks of life. However, PTM recommends that Home State Health post information about the availability of clinical practice guidelines to its members on its website, member handbook, or any other feasible method.
6. Health Information Systems		
a. Home State Health must address signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. Also, EQRO suggested that Home State Health align its claims processing deadlines per RSMo 376.383.	Provider Manual 2022: pages-58, 69, 84 Provider Manual 2022 is updated to align claims processing deadlines. Code for rejecting a claim if a signature is not present is documented, and signature requirements are addressed.	**High**
b. Submit information on the "allowed amount" in the encounter data submitted to the MHD and EQRO for evaluation.	Home State Health informed PTM that the MHD's Encounter data process does not yet accept the "allowed	**Medium** PTM recommends that the MHD updates its Encounter Data process so that MCO can comply with the CFR requirement.

	amount field." As a result, this item is not resolved.	
c. Home State Health must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. EQRO will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.	My Health Application Centene (Home State Health's parent company) implemented Interoperability capabilities, including supporting API interfaces for member claims, provider data, and more.	**High**
EQR 2020		
3. Home State Health should present analysis, evaluation, trends, and recommendations for the future year regarding information related to cultural competence and requests to change practitioners. QAPI 2020 did not include the trends related to cultural competence and change requests for PCPs.	Home State Health submitted the most recent QAPI 2022 (evaluation period-CY 2021) for reviewing the ERQO recommendations. QAPI 2022: pages-102 to 104	**High**
4. Home State Health is required to provide analysis and evaluation of a summary of services provided to members with visual or hearing impairments or who are physically disabled (e.g., Braille, large print, cassette, sign interpreters); an inventory of member materials available in alternative formats. QAPI 2020 did not include data for trends and analysis and a future action plan for improvement.	QAPI 2022: pages-104 to 108	**High**
5. Trends, analysis, and evaluation of information systems in relation to membership and providers must be provided in QAPI.	QAPI 2022: page 142 Process and procedures to meet member and provider needs are described.	**Low** Data analysis about membership and providers is not presented in the QAPI. The same recommendation applies.

6. Home State Health should evaluate and analyze integrated physical and behavioral health CM data.	QAPI 2022: pages-82, 83 Reduction in member cost pre-care coordination and post-intervention is reported. A description of the Pregnancy/Substance Use Disorder (SUD) Program is provided in QAPI 2020 previously.	**Low** There are no trends or analyses for the integrated CM services for Behavioral and physical health. The same recommendation applies.
7. Home State Health has not provided analysis and evaluation of Average Length of Stay (ALOS); Readmissions/1000 members; Emergency Department Utilization (EDU)/1000 members; Outpatient Visits (OPV)/1000 members; Inter-Rater Reliability; Timeliness of Prior Authorization/Certification Decision Making.	QAPI 2022: Pages-116, 117, 119 to 131 The readmission rate is not presented per 1000 members.	**High** PTM recommends that Readmissions data be presented per 1000 members (not in %)as required in the MHD contract.

4.3 Findings, Analysis, Conclusions, and Recommendations: Healthy Blue

EQR 2022 assessed seven federal regulations, with Healthy Blue achieving a compliance score of 76.5%. Table 4-14 summarizes the findings from the first (EQR 2021) and second year (EQR 2022) of the current three-year review cycle (EQR 2021-2023).

Table 4-14: Compliance Summary for EQR 2021-2022

		Number of Sections						
42 CFR 438/457	Medicaid/CHIP Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Confidence Level
438.206 457.1230(a)	Availability of services	10	5	5	0	15	75	Moderate
438.207 457.1230(b)	Assurances of adequate capacity and services	14	2	11	1	15	53.6	Low
438.208 457.1230(c)	Coordination and continuity of care	19	15	3	1	33	86.8	Moderate
438.210 1230(d)	Coverage and authorization of services	19	16	3	0	34	89.5	Moderate
438.214 457.1233(a)	Provider selection	14	5	1	8	11	39.3	Low
438.224 457.1110	Confidentiality	22	18	2	2	38	86.4	Moderate

438.228 457.1260	Grievance and appeal system	34	22	12	0	56	82.4	Moderate
Overall Result EQR 2022 (2-Year)		**132**				**202**	**76.5**	**Moderate**
438.56 457.1212	Disenrollment: Requirements and limitations	18	14	3	1	31	**86.1**	Moderate
438.100 457.1220	Enrollee rights	18	8	10	0	26	**72.2**	Low
438.114 457.1228	Emergency and post-stabilization services	12	11	1	0	23	**95.8**	High
438.230 457.1233(b)	Subcontractual relationships and delegation	12	10	2	0	22	**91.7**	High
438.236 457.1233(c)	Practice guidelines	06	6	0	0	12	**100**	High
438.242 457.1233(d)	Health information systems	16	7	7	2	21	**65.6**	Low
Overall Result EQR 2021 (1-Year)		**82**				**135**	**82.3**	**Moderate**

Compliance Score % = Total Score X100
Total Sections X 2 points

4.3.1 Quality, Timeliness, and Access

Healthy Blue's strengths and weaknesses in the healthcare services in the domain of Quality, Timeliness, and Access to Care are summarized as follows.

Regulation I- Availability of Services.

Strengths.

a. Healthy Blue complies with the geographic standards set forth by the State of Missouri per 20CSR 400-7.095-HMO Access Plans and State of Missouri Distance standards. Upon enrollment, each member is assigned to a PCP no further than 10, 20, or 30 miles from their residence, depending on whether the Department of Commerce and Insurance classifies the county of residence as urban, basic, or rural, respectively. During the interview, the staff was knowledgeable about the geographical access reporting system Healthy Blue utilized to track the provider-member ratio and geographic distribution of providers and members. **(Timeliness, Access to Care)**

b. Healthy Blue disseminates the appointment standards of the MHD program and the contractual requirements through the provider manual, provider newsletter, and provider representative office visits to all participating providers. Healthy Blue members shall be informed about appointment standards through Healthy Blue's member handbook and Customer Service Department. Members are encouraged to contact Healthy Blue Customer

Service Department if appointment standards are not reasonably met. **(Timeliness)**

c. Network Management Department, in conjunction with input from several departments and providers, regularly monitors network adequacy parameters on both a scheduled and ad-hoc basis. Healthy Blue's Provider Relations (PR) or its vendor will survey a portion of the provider network to monitor compliance with appointment standards quarterly. A CAP is initiated for the non-compliant providers**. (Quality, Timeliness, Access to Care)**

d. Healthy Blue provides the option of an independent assessment of the medical necessity for a treatment plan and the medical care options for a treatment plan or elective surgical procedures so that the member can make an informed choice. The second opinion may be both in-network and out-of-network when requested by a member and at no cost to the member**. (Quality, Access to Care)**

e. Healthy Blue authorizes treatment by the out-of-network providers and executes single case or blanket letters of agreement to ensure that members have access to all medically necessary care at no greater cost than they would incur if a network provider saw them. **(Access to Care)**

f. During the interview, Healthy Blue informed PTM that they are in the process of earning a distinction from the NCQA in multicultural healthcare and has a work plan for its implementation. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-15.

Table 4-15. Availability of Services

Weakness	EQRO Recommendation
a. The provider manual states that PCPs should offer routine/preventive care appointments within 6 weeks.	Update the provider manual to reflect the correct appointment timeframe for routine/preventive care within 30 calendar days.
b. None of the policies addressed the requirement of ensuring that the network providers offer hours of operation that are no less than those offered to commercial enrollees or comparable to Medicaid FFS.	The policy should incorporate the requirement and describe the process for ensuring no discrimination related to the work hours of Medicaid enrollees.
c. The policies partially addressed the contractual requirements regarding Access	Update documentation to include:

and Cultural consideration per the MHD contract, section 2.3.1.	The MCO shall regularly inform the public about the MCO's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.
d. The policy, "Development of Marketing and Member Communications," incorrectly states that the marketing and education materials are deemed approved if a response from the state agency is not returned within 30 calendar days following receipt of the materials by the state agency.	Update policy. The marketing and education materials are not deemed approved if there is no response from the MHD within 30 calendar days, per the MHD contract.
e. The providers must provide physical accessibility to Missouri Managed Care members was not addressed in any policy. However, Healthy Blue updated its policy, "Access and Availability-After Hours-MO," to meet the requirements after PTM identified the deficiency.	Communicate the accessibility requirements to Healthy Blue network providers and send the updated policy to the MHD for approval.
f. A policy that allows members direct access to the services of the in-network OB/GYN of their choice to provide covered services (women's routine and preventive healthcare services) was not submitted.	Submit policy and procedure on the provision of direct access to the OB/GYN providers for its female enrollees.

Regulation II- Assurances of Adequate Capacity and Services.

Strengths.

a. The responsibilities of Primary Care Providers (PCPs) are documented in policies and communicated to the providers via the provider manual. The PCPs may have formalized relationships with other PCPs to see their members for after-hours care, certain days, certain services, or other reasons to extend their practice. **(Access to Care)**

b. Healthy Blue received an "Approved" status for its Annual Access Plan 2021 from the Department of Commerce and Insurance. The plan describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues. (Note: PTM did not review the Access Plan as the Network Adequacy assessment is out of scope for EQRO and currently carried out by the State.) **(Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-16.

Table 4-16. Assurances of Adequate Capacity and Services

Weakness	EQRO Recommendation
a. None of the policies specified the types of provider Healthy Blue ensures to include in its network. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiency.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.
b. A policy to show that Healthy Blue maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area was not available during the review period. Also, there was no documentation in any policy to show that Healthy Blue does not require an exclusive relationship or not advertise/hold itself out with any provider. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," to meet all the requirements after PTM identified the deficiencies.	Same comment as above.
c. Provider Manual includes all the specialties eligible to serve as PCPs except for OB/GYN.	Update provider manual.
d. A policy for physicians serving as PCPs in institutions with teaching programs and specialists serving as PCPs for members with chronic and disabling conditions was not submitted. Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review after PTM identified the deficiency.	Submit the revised policy, "Primary Care Provider Responsibilities," for the MHD's approval.

e. Policy/procedure to comply with the requirement that Healthy Blue shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults was not submitted. The provider network, including Community Behavioral Health Organizations (CCBHOs) and Community Mental Health Centers (CMHCs), was not documented. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.
f. Policy and procedure to contract with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Family Planning and Sexually Transmitted Disease (STD) Treatment Providers, local public health agencies, tertiary care centers, pediatric hospitals, dental services in school settings in the network were not available during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," to include all the requirements after PTM identified the deficiencies.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval. Healthy Blue should submit an agreement with each local public health agency and Family Planning and STD treatment provider not in the provider network describing, at a minimum, care coordination, medical record management, and billing procedures.
g. No policy or procedure was submitted to comply with the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies.	Submit the revised policy, "Network Development, Monitoring and Management-MO," for the MHD's approval.

h. Policy and procedure to comply with the requirement of network changes that would affect the adequacy of capacity, services, benefits, and geographic service areas have to be notified to the MHD within the timeframe of five business days were not available during the review period. Healthy Blue revised its policy, "Network Development, Monitoring and Management-MO," after PTM identified the deficiencies. However, the revised policy did not include Healthy Blue's actions regarding enrolling a new population to maintain network adequacy.	Submit documentation to show Healthy Blue's steps to maintain network adequacy when a new population is enrolled.

Regulation III- Coordination and Continuity of Care

Strengths.

a. Healthy Blue will contact the members within five business days of Healthy Blue's notification of anticipated enrollment from the State. To the extent provider capacity exists, Healthy Blue will offer freedom of choice to members in making a PCP selection. Members are responsible for contacting their primary care providers as their first point of contact when needing medical care. **(Access to Care)**

b. Healthy Blue has policies and procedures that address the transition of care requirements for newly enrolled members from other MCOs or Fee-For-Service (FFS) programs. **(Quality, Timeliness)**

c. Relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if Healthy Blue changes subcontractors. **(Timeliness)**

d. Healthy Blue coordinates with an out-of-network provider and the previous MCO to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with physical health or behavioral health provider not in Healthy Blue's network. Healthy Blue shall facilitate securing a member's records from the out-of-network providers as needed and pay rates comparable to FFS for these records unless otherwise negotiated. **(Quality, Timeliness)**

e. Healthy Blue facilitates continuity of care for medically necessary covered services and is responsible for the costs of continuing such services without prior approval and

without regard to whether such services are being provided by in-network or out-of-network providers. The services will continue for the lesser of 60 calendar days or until the member has transferred to an in-network provider without disrupting care. **(Quality, Timeliness, Access to Care)**

f. Members in the third trimester of pregnancy will continue to receive services from their prenatal care provider (whether in-network or out-of-network), without prior authorization, through the postpartum period (defined as 60 calendar days from the date of birth). All pregnant members will continue to receive services from their behavioral health treatment provider without prior authorization until the birth of the child, the cessation of pregnancy, or loss of eligibility. **(Timeliness)**

g. Healthy Blue does not require prior authorization during the transition of care for inpatient and residential treatment days. **(Timeliness, Access to Care)**

h. The providers will maintain a medical record of all services rendered by them and other referral providers. The providers will share records subject to applicable confidentiality and HIPAA requirements. **(Quality)**

i. In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable administrative, technical, and physical safeguards to protect PHI, Personal Information (PI), and Protected Financial Information (PFI), including confidential and proprietary information from unauthorized Use or Disclosure. **(Quality)**

j. Healthy Blue coordinates services for the members who are in health homes. Care gaps or areas of duplication through a mutually acceptable method are identified. During the interview, Healthy Blue informed PTM about a pilot program initiated in May 2021 involving monthly rounds with Two Health Homes. The collaboration focuses on high utilizers, collaboration for engagement, and improving coordination. Healthy Blue creates reports to share with the Health Home, including utilization metrics (Emergency Room, In-Patient, and PCP visits) and top utilizers. **(Quality)**

k. During the interview, Healthy Blue informed PTM that State Enrollment Broker's Health Risk Assessment (HRA), Internal HRA, and member portal identifies members with special healthcare needs. Members who answer positively to special health care need conditions/diagnoses automatically queue to Healthy Blue's care management system and trigger care management (CM) outreach and assessment. An interactive assessment is housed on the member portal. Questions include member demographics, personal health history, self-perceived health status, behavioral health strategies, and queries to identify members with special needs. Using information gathered through the assessment process,

including a review of the relevant evidence-based clinical guidelines, the care manager develops an individualized CM plan, including prioritized goals that consider the member and caregivers' goals and preferences and the desired level of involvement. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-17.

Table 4-17. Coordination and Continuity of Care

Weakness	EQRO Recommendation
a. Documentation on the timeframe (90 days) for conducting an initial screening for the need assessment of its members after enrollment to Healthy Blue was not submitted.	Update policy, "Initial Health Risk Screening Guidelines for Care Management-MO."
b. Policies and procedures to address the requirements of the Hospital Care Transition (HCT) program to integrate with, and enhance the discharge planning and care transition activities of the hospital, as required by the CMS, were not submitted. However, a policy that addressed some of the discharge planning activities was submitted.	The MHD contract, section 2.11.4(a)(1) requires Healthy Blue to have written policies and procedures for the HCT program and states that this program does not replace the MCO's existing member care management, disease management, or utilization management (UM) programs required under this contract.
c. The policy, "Complex Care Management-MO," does not mention updating a member's care plan.	Update policy about revising member's care plan at least annually and in other circumstances per the MHD contract, section 2.11.1.
d. Direct access and standing referrals to a specialty care center if the member has a life-threatening condition or disease requiring specialized medical care over a prolonged period are not addressed in any policy.	Submit documentation.

Regulation IV- Coverage and Authorization of Services.

Strengths.

a. Healthy Blue shall ensure Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called Healthy Children and Youth-HCY program in Missouri) are conducted on all eligible members under the age of 21 years to identify health and developmental problems. Healthy Blue has an established process for reminders, follow-

ups, and outreach to members, e.g., notifying the parent(s) or guardian(s) of children of the needs and scheduling periodic well-child visits according to the periodicity schedule. **(Timeliness, Access to Care)**

b. Prohibition of prior authorization for emergency medical and behavioral health services, involuntary detentions (96-hour detentions or court-ordered detentions), or commitments for any inpatient days while the court order or commitment is in effect. **(Timeliness, Access to Care)**

c. Compliance with the Wellstone–Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA), as applicable to Medicaid MCOs. **(Quality)**

d. A referral, assessment, or other requirements prior to the member accessing requested medical or behavioral health; such requirements shall not impede the timely delivery of the medically necessary service. **(Timeliness)**

e. A professional with experience or expertise comparable to the provider requesting the authorization reviews all appeals and denials and makes UM denial decisions. **(Quality)**

f. Interim supply of an item is available during the authorization process. Member's treatment regimens are not interrupted or delayed (e.g., physical, occupational, and speech therapy; psychological counseling; home health services; personal care) by the prior authorization process. Payment of custom items (e.g., custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) delivered or placed within six months of approval are made even if the member's enrollment ends. **(Access to Care)**

g. Healthy Blue shall not subsequently retract its authorization, revoke, limit, condition, or otherwise restrict a prior authorization after services have been provided or reduce payment for an item or service (except under some circumstances-misinterpretation or omission of health information, contract termination, coverage termination). **(Access to Care)**

h. Healthy Blue does not deny the physician's request for continuing coverage of an inpatient hospital stay unless an alternative service is recommended by Healthy Blue and scheduled within seven days of discharge that meets the medical needs of the member. **(Timeliness, Access to Care)**

i. Compliance with the timeframes for prior authorization decisions for non-emergency services as determined by emergency room staff (30 minutes), urgent services (24 hours),

and standard services within 36 hours of service request. Healthy Blue provides written notification of adverse decisions to the requesting practitioner and member. **(Timeliness)**

j. Healthy Blue does not reward or penalize practitioners, subcontractors, or other individuals (including associates) for issuing denials of coverage of care for financial incentives or nonfinancial incentives such as paid time off. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-18.

Table 4-18. Coverage and Authorization of Services

Weakness	EQRO Recommendation
a. Healthy Blue did not identify, define, and specify the amount, duration, and scope of services required to offer categorically needy and medically needy members that are sufficient to achieve its purpose.	Submit documentation.
b. Policies did not address the services to be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS.	Submit documentation.
c. The policy "Clinical Criteria for UM Decisions-Core Process-MO" is inconsistent in defining the criteria that constitute "Medical Necessity." Another policy, "Concurrent Review (Telephonic and Onsite) and Onsite Review Protocol Process-Core Process-MO," does not fully comply with all the "Medical Necessity" criteria.	Update policies to define "Medical Necessity accurately.
d. Policy on protecting and enabling the enrollee's freedom to choose the method of family planning was not submitted.	Submit policy.

Regulation V- Provider Selection.

Strengths.

a. Healthy Blue verifies the credentialing data, including a license to practice in the state(s) where the practitioner will be treating members. The credentialing department

performs ongoing monitoring (monthly) to help ensure continued compliance with credentialing standards and assess for occurrences that may reflect substandard professional conduct and competence issues. The Council for Affordable Quality Healthcare (CAQH) ProView system is utilized for practitioners. **(Quality)**

b. A practitioner is screened for Medicare, Medicaid, or Federal Employees Health Benefits (FEHB) Program sanctions. An applicant must not be currently federally sanctioned, debarred, or excluded from participating in the following programs: Medicare, Medicaid, or FEHBP. **(Quality)**

c. Healthy Blue will not discriminate against any applicant based on the risk of the population they serve or against those who specialize in treating costly conditions. **(Quality)**

d. Healthy Blue's Supplier Diversity Program is dedicated to diversifying its supplier base to include minority-owned, women-owned, veteran-owned, LGBT (Lesbian, Gay, Bi-Sexual, Transgender)-owned, and disabled-owned businesses wherever possible. Healthy Blue actively works to include diverse suppliers in every bidding opportunity. Healthy Blue has established a 12% Supplier Diversity goal. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-19.

Table 4-19. Provider Selection

Weakness	EQRO Recommendation
a. Healthy Blue did not submit a policy and evidence of an audit of medical records as a part of the re-credentialing process to determine if the providers meet the Advance Directives requirements.	Submit documentation.
b. No documentation on "Ownership or Controlling Interest Disclosure," "Transaction Disclosure," and "Provider and Subcontractor Disclosure" was submitted. Verifying documentation from Missouri Medicaid Audit & Compliance (MMAC) was not submitted, confirming that MMAC has maintained all provider credentialing information.	Develop policy and procedure to meet this section's requirements and submit any waiver they have received from MMAC.

c. No documentation was provided to show provisions in its subcontracts for health care services notifying the provider or benefits management organization to provide the disclosures (as noted in section b above) to Healthy Blue.	Submit documentation.
d. Healthy Blue did not have a policy about notifying the state agency of any denial of enrollment due to the provider credentialing or re-credentialing process results during the review period. However, Healthy Blue updated its policy, "Missouri Medicaid Supplemental Credentialing Policy," to include the requirements after PTM identified the deficiency during the preliminary review. Healthy Blue did not submit enrollment data to show any denials or provider terminations during CY 2021 that met the requirements of this section.	Submit the policy, "Missouri Medicaid Supplemental Credentialing Policy," for the MHD's approval. Submit documentation for enrollment denials during CY 2021.
e. Healthy Blue did not have a policy to meet the requirements of loading the credentialed providers into the claim adjudication and payment system within the time frames provided in the MHD contract, section 2.18.8(c). Healthy Blue updated its policy, "Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times," to include the requirements after PTM identified the deficiency. Healthy Blue did not submit data to show the turnaround time for uploading the provider data into the claim adjudication and payment system.	Submit policy, "Anthem Provider Data Operations (APDO) Provider Data Updates-Turnaround Times," for the MHD's approval. Submit documentation on the turnaround time for uploading the provider data into the claim adjudication and payment system.
f. No documentation on the payment cycle and loading the provider data in the provider directory was submitted.	Submit documentation.
g. Data on compliance with the credentialing timeframe and the number of	Submit credentialing data for CY 2021

providers who were not credentialed according to the requirements by provider type was not submitted.	
h. The policy, "Credentialing," did not include all the nondiscrimination laws per the MHD contract, section 2.2.7.	Update policy, "Credentialing,"

Regulation VI- Confidentiality.

Strengths.

a. Healthy Blue associates must read and sign Healthy Blue's Privacy Policy Summary document, which is part of the new hire Ethics, Privacy, Information Security, Compliance training program online. Temporary workers who are on-boarded through the Fieldglass system must complete the Healthy Blue Overview for Temporary Workers and Contractor education materials (provided by the supplier agency), including signed certification documents, before beginning work functions and annually after that. **(Quality)**

b. In accordance with 45 CFR 164.530(c), Healthy Blue has implemented reasonable Administrative, Technical and Physical safeguards to protect PHI, PI, and PFI, including confidential and proprietary information, from unauthorized Use or Disclosure. The PHI can be in any form, including verbal, written, and electronic. Administrative safeguards apply for oral communications, telephone messages, faxes, emails, copying and printing, clean desk policy, removal of PHI, destruction standards, usage of sensitive financial information, and external business controls. **(Quality)**

c. Authorized Healthy Blue associates may disclose the minimum amount of PHI necessary to comply with a request from a regulatory body that has authority over Healthy Blue. Healthy Blue associates take appropriate steps to verify the identity and authority of the individual, requesting that their PHI be disclosed prior to processing an authorization. **(Quality)**

d. The Disclosure of Substance Use Disorder (SUD) information complies with all applicable Federal and State privacy laws, including 42 CFR Part 2 rules for the Confidentiality of Substance Use Disorder Patient Records, promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA). **(Quality)**

e. An individual authorization is required before Healthy Blue can disclose the Sensitive Services information. Some examples of Sensitive Services may include but are not limited to records relating to HIV/AIDS, mental health, reproductive services, abortion, abuse,

genetic information, and substance use disorder. **(Quality)**

f. Healthy Blue complies with the Health Information Technology for Economic and Clinical Health (HITEC) Act, the HIPAA Omnibus Final Rule, applicable federal (45 CFR 164.400 to 164.414), state and applicable international laws and regulations, and applicable contractual obligations. Healthy Blue may disclose PHI to the subcontractor only if: a Business Associate Agreement (BAA) is in place with the subcontractor; and the BAA contains the same restrictions and conditions that apply to Healthy Blue regarding safeguarding PHI. **(Quality)**

g. Healthy Blue workforce members will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person who is testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under the Administrative Simplification Provisions of the HIPAA. Health Blue shall immediately report breaches identified by completing the Probability of Compromise. **(Quality, Timeliness)**

h. Healthy Blue associates may disclose the minimum amount of PHI necessary without the individual's authorization to perform Healthy Blue's Treatment, Payment, and Healthcare Operations (TPO). Healthy Blue may disclose PHI without authorization in response to a court or administrative tribunal order, a subpoena, a discovery request, or other lawful processes. **(Quality)**

i. Healthy Blue follows contractual requirements that restrict de-identification or limit the use of de-identified data. Requests to create a limited data set for external disclosure should be submitted to the Privacy Department for approval. Limited Data Sets can only be disclosed if the Privacy Department determines, in consultation with the Legal Department, that Healthy Blue enters into a Data Use Agreement with the Limited Data Set recipient prior to the disclosure that allows Healthy Blue to terminate the Data Use Agreement if the agreement is violated. **(Quality)**

j. Healthy Blue shall provide an accounting of disclosures of PHI regarding an individual; and the access to the PHI in an individual's designated record set to the MHD by no later than five calendar days of the request. **(Timeliness)**

k. Health Blue shall immediately report breaches identified by completing the Probability of Compromise analysis. **(Timeliness)**

l. Consistent with Healthy Blue's Records Management Policy and the HIPAA privacy rule, Healthy Blue must retain specified documentation for at least six years from its

creation or when it was last in effect. Healthy Blue may be required to retain records over six years to the extent required under Healthy Blue's Records Retention Schedule. **(Timeliness)**

m. Except as otherwise permitted under HIPAA, Healthy Blue associates may not use or disclose PHI for marketing purposes without an individual's authorization for marketing which must state that the Covered Entity may receive direct or indirect remuneration from the party whose product is being described in the Marketing activity. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-20.

Table 4-20. Confidentiality

Weakness	EQRO Recommendation
a. None of the policies stated that member reports, documentation, or material prepared, as required by the MHD contract, would be released to the public only with the prior written consent of the state agency (MHD contract, section 3.16.1).	Include the requirement from the MHD contract in a policy.
b. Policy to comply with the usage of PHI to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B), (MHD contract 2.38.2(f)) is not submitted.	Submit documentation.
c. Healthy Blue's BAA does not state the timeframe (10 calendar days) within which a BA will submit documentation (internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of PHI) to the Covered Entity (State, Secretary of the Department of Health and Human Services) on request.	Update BAA and disseminate the information to the BAs.
d. Documentation to comply with the timeframe (5 calendar days) requirement of the State for accessing the PHI (Designated Record Set) was not submitted.	Update policy, "Right of Access to Inspect/Copy PHI."

e. Documentation to show that Healthy Blue shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s), or subcontractor(s), was not submitted.	Submit documentation.

Regulation VII- Grievance and Appeal System.

Strengths.

a. Healthy Blue has a grievance and appeal system for members that defines their rights regarding disputed matters with Healthy Blue. Healthy Blue's grievance and appeal system include a grievance and appeals process and access to the State's Fair Hearing process as outlined in the MHD contract, section 2.15 and 42 CFR 438.402. **(Quality)**

b. The member service representatives try to resolve all inquiries during the initial call. Any inquiry that cannot be resolved to the member's satisfaction is documented as a grievance. **(Quality)**

c. Healthy Blue's policies comply with the requirements: persons who have the authority to file; procedure to file a grievance, appeal, or a State Fair Hearing; timings of notice of adverse benefit determination; acknowledging each grievance and appeal in writing (within 10 business days after receiving a grievance or appeal); timely filing (within 10 calendar days of notification) for the continuation of benefits when an appeal or State Fair Hearing is pending; extension timeframes of appeals (not more than 14 calendar days); the format of notice of resolution; and process for an expedited resolution of appeals. **(Quality, Timeliness)**

d. Healthy Blue gives members reasonable assistance in completing forms and taking other procedural steps related to a grievance or an appeal. The assistance includes but is not limited to auxiliary aids and services upon requests, such as providing interpreter services for members/authorized representatives with limited English proficiency and toll-free numbers that have adequate TTY/TTD (Teletypewriter/Telecommunications Device for the Deaf) and interpreter capability and American Sign Language services for members and authorized representatives with visual or other communicative impairments and challenges. **(Quality)**

e. The member or the member's representative may request the member's case file free of charge, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Healthy Blue in connection

with the appeal of the adverse benefit determination. Healthy Blue will ensure that members and authorized representatives acting on behalf of the member will not receive punitive action for requesting the appeal and have a full and fair process to appeal, either verbally or in writing, any adverse decision (e.g., benefit, coverage, quality of care, administrative). **(Quality)**

d. Healthy Blue is knowledgeable of its role after the final resolution of the appeal or State Fair Hearing. If the decision is against the enrollee, Healthy Blue may recover the cost of services furnished to the enrollee for the period appeal or State Fair Hearing was pending. Healthy Blue must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the adverse benefit determination. **(Quality, Timeliness)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-21.

Table 4-21. Grievance and Appeal System

Weakness	EQRO Recommendation
a. Even though the definitions of grievance, appeal, grievance and appeal system, inquiry, adverse benefit determination, and State Fair Hearing are accurately defined in the policies, the provider manual does not include an accurate definition of adverse benefit determination and appeal.	Update the provider manual with accurate definitions of adverse benefit determination, and appeal per 42 CFR 438.400.
b. Healthy Blue did not submit its member flyer for review as requested.	Submit member flyer.
c. The member handbook does not mention the timing for filing a grievance.	Update member handbook.
d. The policy, "Member Appeals-MO," states that the medical director or the practitioner who made the initial decision may review the case and overturn their initial decision.	Update the policy and procedure. An appeal is not reviewed by a medical director or a practitioner who has made an initial decision. This does not comply with 42 CFR 438.406.
e. The timeframe of post-service appeal resolution within 60 days mentioned in the member handbook is not per the MHD contract/CFR.	Update member handbook. Healthy Blue must resolve an appeal within 30 days of filing by a member.

f. The policy, "Member Appeals-MO," states that if Healthy Blue fails to adhere to the notice and timing requirements under the MHD contract, section 2.12.16 (c.)(22), and in accordance with 42 CFR 438.408, the member is deemed to have exhausted Healthy Blue's internal level of appeal and may initiate a State Fair Hearing.	The MHD contract, section 1.12.16(c)(22), does not mention the timeframe requirement. The policy should be updated to exclude this section from its policy and quote the correct section on the timeframe from the MHD contract.
g. The member handbook does not have information to file a State Fair Hearing in case of deemed exhaustion of the appeal process.	Update member handbook.
h. The provider manual has incorrect information stating that a member, or the member's representative, can file an appeal within 90 calendar days from the date of Healthy Blue's notice of action.	Update the provider manual to reflect the correct timeframe of 60 days for filing an appeal after Healthy Blue's notice of adverse benefit determination.
i. The Medical Transportation Management (MTM) Statement of Work (SOW) does not include all the information about the grievance and appeal system that must be provided when they entered a contract with Healthy Blue per 42 CFR 438.414.	Update MTM's SOW.
j. DentaQuest Ancillary Services Agreement states that a provider may file a verbal or written complaint or appeal within 90 days or within the specified time frame of adverse benefit determination.	Update the Dental Quest Ancillary Services Agreement with an accurate timeframe (30 days) and process for filing an appeal (oral or written).
k. Healthy Blue's website for provider resources does not provide grievance and appeal system information. The Quick Reference Guide posted on the website for providers also does not incorporate information. The grievance and appeal system information must be provided to the providers and subcontractors when they enter a contract with Healthy Blue per 42 CFR 438.414.	Update documentation for compliance with the requirement.

l. Healthy Blue did not submit logs of closed and open cases of grievances and appeals for the review period. Thus, PTM could not determine compliance.	Submit records (logs) for CY 2021.
m. Healthy Blue's provider manual requires member records be retained for at least seven years after the last product, service, or supply has been provided to a member or an authorized agent unless those records are subject to review, audit, or investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	The provider manual is updated to reflect the accurate timeframe of record retention per 42 CFR 438.3(u).

4.3.2 Improvement from previous year

Table 4-22 shows the degree to which Healthy Blue responded to PTM's recommendations from the previous year's EQR. PTM reviewed the documents to assess the non-compliant criteria per the CAP and the weaknesses identified in EQR 2021. The response was evaluated and categorized as High, Medium, and Low (Table 4-23), defined in the previous section, 4.2.2 of this report.

Table 4-22. Score for Degree of Response						
Total	High	=	14	×2	=	28
	Medium	=	9	×1	=	9
	Low	=	11	×0	=	0
Numerator	Score Obtained					37
Denominator	Total Sections	=	34	×2	=	68
Overall Score= Low						**54.4%**

Table 4-23. Healthy Blue's Response to the Previous Year's Recommendations

Recommendations	Action by Healthy Blue	Degree of Response
EQR 2021		
1. Disenrollment: Requirements and Limitations		
a. Healthy Blue must incorporate in their policy, "MO29-OP-CS-003 Member Disenrollment," to request disenrollment upon automatic re-enrollment if the temporary loss of	Disenrollment-MO: page 3 Healthy Blue updated the above policy to meet the requirement. Also,	**High**

Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.	merged the information presented in MO29-OP-CS-003 policy into one single policy (stated above).	
b. Healthy Blue incorporate in their policy on Member Disenrollment and implement the member's right to request disenrollment if Healthy Blue does not cover services the member seeks because of moral or religious objections.	Disenrollment-MO: page 3 The policy is updated.	**High**
c. Healthy Blue must have a written procedure for complying with the MHD's disenrollment orders.	Disenrollment-MO: page 6 The Enrollment and Billing Department will process the HIPAA 834 file, and the enrollment transaction will be generated for the MHD in accordance with all contractual requirements.	**Low** Healthy Blue must describe the procedure for disenrollment orders. The same recommendation applies.
d. Healthy Blue should have a documented procedure for receiving enrollment and disenrollment updates and incorporating them daily in Healthy Blue and the subcontractor management system. Healthy Blue should also list the procedure for weekly membership reconciliation with the MHD's 834 files.	Disenrollment-MO: page 6 Same comment as above (section c)	**Low** Healthy Blue must describe the procedure for disenrollment orders. The same recommendation applies.
2. Enrollee Rights		
a. Healthy Blue must have a policy/guideline regarding member resources per 42 CFR 438.10 and revise Welcome Quick Guide to a sixth-grade reading level.	MAMCOM Member Materials-Appropriateness: pages-13, 14 Welcome Quick Guide Flyer (revised-reading level sixth grade)	**Medium** Healthy Blue must update the policy to meet the font size requirements for Taglines in its member materials per 42 CFR 438.10. Taglines are no

		longer required to be of font size 18.
b. Healthy Blue must address the requirement to notify its members 15 calendar days after receipt or issuance of the termination notice to any provider.	Provider Termination Enterprise Playbook (updated snapshot)	**High**
c. Healthy Blue must have a policy about providing a member handbook and other written materials with information on how to access services to all members within 10 business days of being notified by the MHD of their future enrollment with Healthy Blue.	New Member Materials Distribution: page 4	**High**
d. Healthy Blue update its policy, Development of Marketing and Member Communications, and align it with the MHD contract, section 2.13.2. Per the MHD contract, the marketing materials are not deemed approved if there is no response from the State within 30 calendar days.	MAMCOM Member Materials-Appropriateness: page 14 Development of Marketing and Member Communications: page 4	**Medium** HB has submitted another policy that meets the requirement of the MHD contract. However, Healthy Blue has not revised its policy as recommended.
e. Healthy Blue must maintain a log with the changes they made each year to its member handbook, along with the date of approval by the MHD.	Healthy Blue informed PTM that they maintain records of all changes related to the member handbook. All changes are then submitted to the State for approval and recorded accordingly.	**Low** Healthy Blue has not submitted a log with changes in the previous years.
f. Healthy Blue must notify its enrollees of any change the MHD defines as significant in the enrollee handbook at least 30 calendar days before the intended effective date of the change.	Healthy Blue informed PTM that the member Handbook is updated annually per the MHD. They do not recall receiving any significant changes which would require notification to the enrollee.	**Low** Healthy Blue did not submit a policy or documentation to meet the requirement. (Note: PTM suggested Healthy Blue submit evidence as to how they informed the

		potential enrollees about that Medicaid Expansion that was implemented in CY 2020.)
g. Healthy Blue is recommended to update its member handbook to meet all the 48 criteria listed in the MHD contract, section 2.12.16, even though the MHD provides a template.	Member Handbook: pages-36, 49	**Medium** The same recommendation applies.

Findings: Out of 48 criteria required in the member handbook per the MHD contract 2.12.16, six were "Partially Met," and two were "Not Met" during EQR 2021. PTM re-reviewed the revised member handbook 2021 available on Healthy Blue's website and found that four of nine "Partially Met" criteria were addressed. Thus, five criteria remain "Partially Met," and two remain "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows:

h. Information on how and where members can access benefits provided by the State is not present.

t. All the conditions under which an enrollee can disenroll with or without cause are not listed, e.g., upon automatic re-enrollment, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity, the enrollee can request for disenrollment.

v. Time allocated to file a grievance is not addressed. A member must complete a written request for an appeal even if the member filed orally is incorrect (page 58) per 42 CFR 438, effective Dec 14, 2020.

a.9 A statement that Healthy Blue shall protect its members in the event of insolvency, and it shall not hold its members liable under certain conditions as in the MHD contract, is not written.

a.18. Healthy Blue did not include a statement of "any limitation regarding the implementation of advance directives as a matter of conscience," as required per the MHD contract. Healthy Blue informed EQRO that the MHD provides the language for Advance Directives as a template.

The "Not Met" criteria are as follows:

k. A description of all prior authorization or other requirements for treatments and services is missing.

q. How a member with life a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained.		
h. Healthy Blue should consider revising the documentation in Providers Resource on their website on "encouraging members to receive family planning services within the network." Per 42 CFR 441.20, for beneficiaries eligible under the plan for family planning services, the plan must provide that each beneficiary is free from coercion or mental pressure and free to choose the family planning method. The MHD contract, section 2.12.16, states that members may obtain family planning services and supplies from out-of-network providers.	Provider Quick Reference Card: page 4	**Low** Provider Quick Reference Guide posted on the website is not revised.
i. Healthy Blue consistently reports all the provider directory requirements for its providers, including hospitals in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. Healthy Blue should educate its providers about the contractual requirement for submitting their information to Healthy Blue. Healthy Blue should update its policy, Provider Listing Updates, with the missing information about the requirements and submit it to the MHD for approval.	Provider Listing Updates-MO: pages-1 to 3 Physicians and Medical Professional Search (Apr 26, 2022)	**Medium** Healthy Blue has updated its policy. PTM searched the website for a provider directory. The search resulted in a pdf document that did not provide board-certified status, panel status, cultural and linguistic capabilities, or accommodations for all the providers. However, all the information is available online, and the provider directory is posted in a comma-delimited format.

		PTM recommends that Healthy Blue have the ability to provide all the required information in a format that can be easily understood, downloaded, and read on an electronic device by Medicaid members.
j. Healthy Blue uploads its provider directory on its website in a machine-readable format (computer/mobile readable). Members should have access to them once downloaded on their computer or mobile, even without internet accessibility/availability.		**Medium** A PDF document can be generated after searching for the provider on the website. The directory uploaded on the website is in a comma-delimited format that a person with limited IT knowledge will not understand. PTM recommends that Healthy Blue uploads the provider directory in Word or PDF format.
k. Healthy Blue quotes the references from federal regulations in its policy, Member Rights and Responsibilities-MO, which expresses Healthy Blue's commitment to comply with all the regulations on observing and protecting enrollee rights (indiscrimination).	Member Rights and Responsibilities-MO policy is not updated to show the federal regulations covered in its Indiscrimination statement.	**Low**
3. Emergency and Post-stabilization Services		
a. Healthy Blue must submit documentation to show that Healthy Blue and its providers have an agreement on payment for the	Healthy Blue did not submit supporting documentation (Single Case Agreement).	**Low**

emergency and post-stabilization services.		
4. Subcontractual Relationships and Delegation		
a. Healthy Blue must update its contract with March Vision Care Group, Inc. and MTM Inc. with the requirements set in the MHD contract, section 3.9.6 (delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement).	March Vision Care Group, Inc. Amendment (Mar 01, 2017): pages-4, 5, 6, 11 March Vision Care Group, Inc. Fifth Amendment: page 6 MTM Inc. Amendment SOW 1 (Jan 1, 2022): pages-10, 11	**High** Healthy Blue submitted documents that meet requirements related to the deficient items from the previous year's EQR.
b. Healthy Blue must update its agreement with the March Vision Care Group, Inc. to indemnify the State in case of a dispute between Healthy Blue and the subcontracted providers.	March Vision Care Group, Inc. Amendment (Mar 01, 2017): page 10	**High** Same comment as above.
5. Practice Guidelines		
a. Healthy Blue staff's knowledge during the interview and policies, e.g., QIQM-02A Clinical Practice Guidelines-Review, Adoption, Distribution, and Performance Monitoring, must be consistent with each other regarding the frequency of updating practice guidelines. Inconsistent information about the frequency of updating the CPGs-annually or biennially was provided.	Healthy Blue did report any action to resolve the issue.	**Low**
b. Primaris (PTM) recommends that Healthy Blue inform its members about the existence and availability of practice guidelines via member handbooks, newsletters, or mailers and how to request these documents.	Healthy Blue did report any action toward the recommendation.	**Low**
6. Health Information Systems		
a. Healthy Blue must explain/describe its process as to how Healthy Blue's	Grievance and Appeals MIS Overview: pages-1, 2	**Medium**

health information system provides information on the Grievances and Appeals.	Healthy Blue submitted flow charts.	Healthy Blue did not describe how the information system provides information on Grievances and Appeals.
b. Healthy Blue must submit documentation to show that its claims processing system is capable of detecting fraud, waste, and abuse in compliance with section 6504(a) of the Affordable Care Act and 1903(r)(1)(F) of the Act.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acknowledgment of Receipt and Received Date for Electronic Data Interchange (EDI) Submissions: page 2 Reconciliation Ticket Process: pages-3 to 21 Providers_In Queue: pages 1 to 4	**Medium** The policy addresses the accuracy of claims. Healthy Blue is expected to report an expanded set of data elements for the electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) to detect fraud and abuse necessary for program integrity, program oversight, and administration.
c. Healthy Blue has phone-based capabilities to obtain claims processing status information and provide documentation supporting this requirement.	Operational Data Exchange Interfaces (flow chart)	**Medium** The flow chart shows IVR eligibility, claims, and authorization status inquiry. PTM recommends that Healthy Blue describes its process.
d. Healthy Blue must address the federally required safeguard requirements, including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19. The requirements stated in RSMo 376.383 and 376.384 also need to be addressed, and supporting documents be submitted.	Electronic X12 837 CLM06 (Snapshot submitted Electronic Transaction Standard: page 1	**High**

e. Healthy Blue must have policies and procedures to verify the consistency and timeliness of reported data, including data from network providers Healthy Blue compensates based on capitation payments.	Encounters Completeness, Timeliness, and Accuracy Policy: pages-5, 6 Timeliness July 2021 (Snapshot)	**High**
f. Healthy Blue annotate its policy that all data collected will be submitted to CMS and other state agencies if requested.	Encounters Completeness, Timeliness and Accuracy Policy: page 1	**High** Healthy Blue's policy states that they collect and maintain 100% of all encounter data for each covered service and supplemental benefit services provided to Members, including encounter data from any sub-capitated sources for the MHD. The MHD uses the data for federal reporting.
g. Healthy Blue has a policy and supporting documentation on the frequency and acceptance rate of enrollee encounter data to the MHD.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acceptance Rate July 2021 (Snapshot) Encounters Reported July 2021 (Excel)	**High**
h. Healthy Blue has a policy/procedure and submission of all enrollee data, including allowed and paid amounts.	Encounters Completeness, Timeliness and Accuracy Policy: page 6 Acceptance Rate July 2021 (Snapshot) Completeness Monthly Summary Jan-Jul 2021 (Snapshot)	**Medium** The policy meets the requirements of this section except for the submission of allowed claims. The data (snapshots) submitted show only the paid amounts. PTM noted that other MCOs reported their

		inability to submit the allowed amount due to a constraint in the MHD's encounter system process.
i. Healthy Blue develop a policy on the timeframe for submission of encounters to the MHD. Additionally, documentary evidence must be submitted to show that they have complied with this requirement.	Encounters Completeness, Timeliness and Accuracy Policy: page 5 Completeness Monthly Summary (Jan-Jul 2021)	**High**
j. Healthy Blue addresses the requirements, both in its policies and practice, related to the availability of information systems during normal operations and in the event of a major failure or disaster. Healthy Blue is expected to submit documentation to comply with the requirement that critical member and provider Internet and telephone-based functions and information, including critical provider internet and telephone-based functions and electronic claims management, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week. Healthy Blue must address the contractual requirement in the event of a declared major failure or disaster: Healthy Blue's core eligibility/enrollment and claims processing systems shall be back online within 72 hours of the failure's or disaster's occurrence.	No documentation was submitted.	**Low**
k. Application Programming Interface (API) as specified in 42 CFR 431.60 and 431.70. API was required to be implemented by Jan 1, 2021. However, per CMS's letter dated Aug 14, 2020, due to the COVID-19 public health emergency, CMS is exercising	Interoperability API Endpoint Support Healthy Blue confirmed the implementation of API and submitted a supporting document.	**High**

enforcement discretion and does not expect to enforce this requirement prior to Jul 1, 2021. PTM will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.		
EQR 2020		
1. Multilingual Services: An analysis and evaluation of the multilingual services provided, including: A count of members needing communication accommodations due to hearing impairments or a physical disability. Missouri Care (currently dba Healthy Blue) did not report this in QAPI.	Count of Members MO_TTY-TDD (Excel) QAPI Annual Evaluation MY 2021: pages-37, 38	**High** Healthy Blue has created reporting of Multilingual services and a count of members needing communication accommodations due to hearing impairment or a physical disability. Healthy Blue stated that they would report these results in future QAPI reports.
2. Grievances and Appeals: Healthy Blue has reported Member Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. EQRO finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. EQRO recommends that Healthy Blue seek written clarification on expectations from the MHD. Healthy Blue should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	QAPI Annual Evaluation MY 2021: pages-66 to 68 Healthy Blue stated that due to NCQA requirements, these categories would need to remain in the report, and they cannot modify previous reports. In future reports, Healthy Blue will add sub-categories under the definitions of Adverse Benefit Determination as aligned per 42 CFR 4.38.400 and report accordingly.	**Low** Healthy Blue has presented categories based on NCQA but not per the CFR. The same recommendation applies.
EQR 2019		
1. Policy update required: Release of PHI to the public will be only after prior	Healthy Blue has submitted information on	**High**

written consent from the state agency (MHD contract 3.16.1). (Scored as Partially Met).	ensuring a policy is disseminated to all its staff. Ethics and Compliance Certification has instructions for all its employees before releasing any member-related records/data.	Healthy Blue has rules for releasing PHI to public officials and other requesters. However, the release of PHI only after written consent from the state agency is not explicitly mentioned. PTM recommends that Healthy Blue must incorporate this requirement in its policy.

4.4 Findings, Analysis, Conclusions, and Recommendations: UnitedHealthcare

EQR 2022 assessed seven federal regulations, with UnitedHealthcare achieving a compliance score of 87.9%. Table 4-24 summarizes the findings from the first (EQR 2021) and second year (EQR 2022) of the current three-year review cycle (EQR 2021-2023).

Table 4-24. Compliance Summary for EQR 2021-2022

		Number of Sections						
42 CFR 438/457	Medicaid/CHIP Regulation	Total	Fully Met	Partially Met	Not Met	Score	Score %	Confidence Level
438.206 457.1230(a)	Availability of services	10	10	0	0	20	100	High
438.207 457.1230(b)	Assurances of adequate capacity and services	14	3	11	0	17	60.7	Low
438.208 457.1230(c)	Coordination and continuity of care	19	16	3	0	35	92.1	High
438.210 457.1230(d)	Coverage and authorization of services	19	10	9	0	29	76.3	Moderate
438.214 457.1233(a)	Provider selection	14	12	2	0	26	92.9	High
438.224 457.1110	Confidentiality	22	21	1	0	43	97.7	High
438.228 457.1260	Grievance and appeal system	34	28	6	0	62	91.17	High
Overall Result EQR 2022 (Year 2)		**132**				**232**	**87.9**	**Moderate**
438.56 457.1212	Disenrollment: Requirements and limitations	18	18	0	0	36	**100**	High
438.100 457.1220	Enrollee rights	18	13	05	0	31	**86.1**	Moderate

438.114 457.1228	Emergency and post-stabilization services	12	11	01	0	23	**95.8**	High
438.230 457.1233(b)	Subcontractual relationships and delegation	12	08	04	0	20	**83.3**	Moderate
438.236 457.1233(c)	Practice guidelines	06	06	0	0	12	**100**	High
438.242 457.1233(d)	Health information systems	16	05	08	3	18	**56.3**	Low
Overall Result EQR 2021 (Year 1)		**82**				**140**	**85.4**	**Moderate**

Compliance Score % = Total Score X100 = 100%
Total Sections X 2 points

4.4.1 Quality, Timeliness, and Access

UnitedHealthcare's strengths and weaknesses in the healthcare services in the domain of Quality, Timeliness, and Access to Care are summarized as follows.

Regulation I- Availability of Services.

Strengths.

a. UnitedHealthcare complies with the geographic distribution (travel distance) standards and the appointment standards required by the MHD for all enrollees, including those with limited English proficiency or physical or mental disabilities. The services included in the contract are available 24 hours a day, seven days a week, when medically necessary. During the interview, the staff was knowledgeable about the geographical access reporting system UnitedHealthcare utilized to track the provider-member ratio and geographic distribution of providers and members. **(Timeliness, Access to Care)**

b. UnitedHealthcare educates providers on the accessibility of services and availability of practitioners' requirements through written notification when an opportunity is identified and about standards requirements in the provider manual. Member education is provided through the member handbook, which outlines the standards for provider appointment availability. **(Timeliness)**

c. UnitedHealthcare monitors compliance with appointment standards using one or more of the following and shall have a corrective action plan when appointment standards are not met **(Quality)**:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) and supplemental questions.
- Key Member Indicators Survey questions.

- Qualified Health Plan Survey questions.
- Primary Care Practitioner and Specialists Accessibility Surveys.
- PCP After-hours Access Survey.
- Member access complaints.
- Out-of-network service requests and claim utilization.
- Behavioral Health satisfaction survey questions, complaints, treatment record reviews, appointment tracking, and claims data.

d. UnitedHealthcare provides second opinions both in-network and out-of-network when requested by a member are provided at no cost to the enrollee. **(Access to Care)**

e. UnitedHealthcare adequately and timely covers services out-of-network for the enrollee for as long as its provider network cannot provide them. **(Access to Care)**

f. UnitedHealthcare prioritizes its engagement with qualified providers who promote a culturally sensitive environment and embrace the health care provider's role in minimizing health care disparities. Care Provider Manual informs the providers that UnitedHealthcare has developed a Cultural Competency Program to meet its membership needs. **(Quality)**

g. UnitedHealthcare meets the provision of physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities by the providers. **(Access to Care)**

h. UnitedHealthcare allows female members direct access to in-network Obstetrics/Gynecology (OB/GYN) services of their choice for covered services (women's routine and preventive healthcare services) if their PCP is not a women's health specialist. **(Access to Care)**

Weaknesses and Recommendations. No areas of concern were identified regarding the regulation.

Regulation II- Assurances of Adequate Capacity and Services.

Strengths.

a. The provider network includes a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults, including Community Mental Health Centers (CMHCs) and Community Behavioral Health Organizations (CCBHOs). UnitedHealthcare has contracted with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), Local Public Health Agencies, Tertiary Care centers, pediatric hospitals, family planning, and sexually transmitted disease

treatment providers, and dentists. UnitedHealthcare is prepared to implement the Local Community Care Coordination Program (LCCCP) model that focuses on providing care management, care coordination, and disease management through local healthcare providers. UnitedHealthcare contracts with Children's Mercy Health for LCCCP. **(Access to Care)**

b. UnitedHealthcare received an "Approved" status for its Annual Access Plan 2021 from the Department of Commerce and Insurance. The plan describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues. (Note: PTM did not review the Access Plan as the Network Adequacy assessment is out of scope for EQRO and is currently carried out by the MHD.) **(Access to Care)**

c. The MHD is notified of any change in the provider network or UnitedHealthcare's operations that would affect the adequacy of capacity, services, benefits, and geographic service areas within 5 business days of identification of the issue. **(Timeliness, Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-25.

Table 4-25. Assurances of Adequate Capacity and Services

Weakness	EQRO Recommendation
a. None of the policies specified the range of services and provider types that UnitedHealthcare ensures to include in its network.	Update the policy, "NC-65 UHN Monitoring for Community and State (C&S) Network Access and Adequacy," to specify the range of services and provider types that UnitedHealthcare ensures to include in its network.
b. UnitedHealthcare did not submit documentation to show that it does not require an exclusive relationship or not advertise/hold itself out with any provider.	Update the policy, "Accessibility of Services and Availability of Practitioners and Providers," and subcontracts based on the deficiency identified by PTM.
c. The provider manual does not include all the required responsibilities of primary care providers (PCP). Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review process after PTM identified the deficiency.	Update the provider manual to include all the responsibilities of a PCP based on the MHD contract, section 2.4.2(a). The revised policy, "Primary Care Provider Responsibilities," must be submitted to the MHD for approval.

d. A policy for eligible providers serving as PCPs in institutions with teaching programs and specialists serving as PCPs for members with chronic and disabling conditions was not submitted. Revisions to the policy, "Primary Care Provider Responsibilities," were made during the review process after PTM pointed out the deficiency.	Same comment as above.
e. Policy/procedure to comply with the requirement that UnitedHealthcare shall include in its network a mix of mental health and substance use disorder treatment providers with experience in treating children, adolescents, and adults was not submitted.	Submit a policy to include the guidelines about the inclusion of behavioral health professionals, Certified Community Behavioral Health Organizations (CCBHOs), and Community Mental Health Centers (CMHCs) in the provider network.
f. Policy/procedure to show that UnitedHealthcare shall offer a contract to all FQHCs, Provider-Based Rural Health Clinics (PBRHCs), and Independent Rural Health Clinics (IRHCs) at the rates established in the MHD contract was not submitted.	Submit a policy to comply with requirements pertaining to FQHCs and RHCs.
g. UnitedHealthcare did not submit a policy/procedure to include Title X and STD providers. UnitedHealthcare did not submit documentation to show its contract agreement with Family Planning and STD treatment providers not in the network describing, at a minimum, care coordination, medical record management, and billing procedures.	Submit a policy and an agreement template for out-of-network providers to include the minimum requirements describing care coordination, medical record management, and billing procedures.
h. A policy and the list of dental providers were not submitted to support the provision of dental services in a school setting.	Submit documents to support that UnitedHealthcare contracts with and reimburses any licensed dental provider who provides preventive dental services (i.e., dental exams, prophylaxis, and sealants) in a school setting.
i. Policy/guidelines on providing tertiary care services and a process for providing such services, including transfer protocols	Submit documentation.

and arrangements with out-of-network providers, were not submitted.	
j. UnitedHealthcare did not submit policy/guidelines to include specialty pediatric hospitals in its provider network.	Submit documentation.
k. Policy and procedure were not submitted to comply with the requirement that American Indian/Alaskan Natives are permitted to receive care from Indian Health Care Providers (IHCP). UnitedHealthcare reported that there are no IHCPs in Missouri, so they do not have any documentation for submission.	PTM noted information about Native Americans' access to care in UnitedHealthcare's provider manual. However, UnitedHealthcare must comply with all the requirements for access to care per the MHD contract, section 2.4.18, in its policies and procedures.
l. Policy/procedure to include enrollment of a new population impacting UnitedHealthcare's operations was not submitted.	Incorporate procedure for assessing UnitedHealthcare's readiness for accommodating a newly enrolled population.

Regulation III- Coordination and Continuity of Care

Strengths.

a. All members select or are assigned to a single practitioner responsible for coordinating care and making referrals to specialists for the enrolled population. **(Access to Care)**

b. UnitedHealthcare has a policy and procedure that addresses the transition of care requirements for newly enrolled members from other MCOs or Fee-For-Service (FFS) programs. **(Quality, Timeliness)**

c. UnitedHealthcare ensures that relevant enrollee information is transferred between the subcontractors in a timely manner before transitioning to the new subcontractor if UnitedHealthcare changes subcontractors. **(Timeliness)**

d. UnitedHealthcare coordinates with an out-of-network provider and the previous MCO to effect a smooth transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with physical health or behavioral health provider who is not in UnitedHealthcare's network. UnitedHealthcare shall facilitate securing a member's records from the out-of-network providers as needed and pay rates

comparable to FFS for these records unless otherwise negotiated. **(Quality, Timeliness)**

e. UnitedHealthcare facilitates continuity of care for medically necessary covered services and is responsible for the costs of continuing such services without prior approval and without regard to whether such services are being provided by in-network or out-of-network providers. The services will continue for the lesser of 60 calendar days or until the member has transferred to an in-network provider without disrupting care. **(Quality, Timeliness, Access to Care)**

f. Members in the third trimester of pregnancy will continue to receive services from their prenatal care provider (in-network or out-of-network), without prior authorization, through the postpartum period (defined as 60 calendar days from the date of birth). All pregnant members will continue to receive services from their behavioral health treatment provider without prior authorization until the birth of the child, the cessation of pregnancy, or loss of eligibility. **(Timeliness)**

g. Prior authorization during the transition of care for inpatient and residential treatment days is not required. **(Timeliness, Access to Care)**

h. UnitedHealthcare's Privacy and Security Programs are designed to comply with federal and state privacy laws and regulations, including, as applicable, HIPAA, HITECH Act, the Gramm-Leach-Bliley Act (GLBA), Children's Online Privacy Protection Rule (COPPA), and state privacy laws including but not limited to the California Consumer Privacy Act (CCPA). **(Quality)**

i. UnitedHealthcare may use a Section 2703 designated health home provider to perform disease management functions if the health home provider is a member of UnitedHealthcare's network. **(Access to Care)**

j. UnitedHealthcare has policies and procedures that address the requirements of the Hospital Care Transition (HCT) program to integrate with and enhance the discharge planning and care transition activities of the hospital as required by the CMS. UnitedHealthcare coordinates the services to the enrollees between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. **(Quality)**

k. UnitedHealthcare provides services for enrollees with special health care needs. The care manager reviews the referral source and risk stratification data to identify complex or special needs, current risks as well as the utilization history of a member. All new members entering UnitedHealthcare are screened for care management programs via a health risk

assessment (HRA) tool or may receive a more comprehensive assessment based on program needs. A person-centered, evidence-based plan of care (POC) is developed by the care manager in collaboration with the member, caregiver/family (with the member's consent), and the interdisciplinary care team. The team includes the member's PCP, other medical and behavioral health providers, and external care managers involved in the member's care. **(Quality, Access to Care)**

i. UnitedHealthcare permits direct access and standing referrals for a specialist or specialty care center in case of a member's chronic or life-threatening condition. Also, a standing referral to an out-of-network provider is provided if UnitedHealthcare does not have a provider with the required training and experience within its network. **(Access to Care)**

j. During the interview, UnitedHealthcare reported that in the fall of 2020, they launched a pilot program focusing on providing homeless people housing, shelters, and food. **(Quality, Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-26.

Table 4-26. Coordination and Continuity of Care

Weakness	EQRO Recommendation
a. UnitedHealthcare did not submit information on the timeframe (90 days) within which they are required to screen all new enrollees to assess their needs.	Update the policy, "Identification of High-Risk Members for Care Management," to mention the timeframe for compliance.
b. UnitedHealthcare did not submit documentation to show that each provider furnishing services to enrollees maintain and shares, as appropriate, an enrollee health record in accordance with professional standards to prevent duplication of those activities.	Submit policy and ensure that the requirement of maintaining and sharing enrollee health records is met.
c. Hospital Care Transition (HCT) plan does not include onsite coordinators to work directly with the hospital staff to assist members in their care transition.	Update the Discharge Care Management Review Workflow to include the coordinator's presence onsite at the facility. When members are identified with an admission requiring HCT management services, the coordinators must work directly with the hospital staff to assist

	members in their care transition. This requirement can be implemented after the Covid-19 pandemic restrictions are no longer necessary.
d. UnitedHealthcare's "Case Management Process" policy has incorrect information on completing the assessment within 60 days.	Update policy, "Case Management Process," to reflect the completion time of care management assessment within 30 calendar days of receiving a notification/identification.

Regulation IV- Coverage and Authorization of Services.

Strengths.

a. UnitedHealthcare coordinates services with child-serving agencies and providers, provision of all medically necessary individualized Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services (called as Healthy Children and Youth-HCY program in Missouri), and arrangements for necessary follow-up care regardless of whether the required service is a covered benefit. **(Access to Care)**

b. UnitedHealthcare prohibits requiring prior authorization for emergency medical and behavioral health services, involuntary detentions (96-hour detentions or court-ordered detentions), or commitments for any inpatient days while the court order or commitment is in effect. **(Timeliness, Access to Care)**

c. UnitedHealthcare conducts and supports ongoing quality monitoring of MHP regulatory requirements as defined by the Mental Health Parity and Addiction Equity Act (MHPAEA), 21st Century Cures Act, 2021 Consolidated Appropriations Act (CAA), and all applicable federal or state-specific MHP laws and regulations. **(Quality)**

d. UnitedHealthcare's denial of a service authorization request or authorizing service in an amount, duration, or scope that is less than requested is made by an individual with appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and support needs. **(Quality)**

e. UnitedHealthcare is responsible for payment of custom items (e.g., custom or power wheelchairs, eyeglasses, hearing aids, dentures, custom HCY/EPSDT equipment, or augmentative communication devices) delivered or placed within six months of approval, even if the member's enrollment in UnitedHealthcare ends. **(Access to Care)**

f. Prior Authorization decisions are made within 36 hours, which shall include one working day of obtaining all necessary information for routine services. UnitedHealthcare

notifies the requesting provider and gives the enrollee written notice of any decision by UnitedHealthcare to deny a service authorization request or to authorize service in an amount, duration, or scope that is less than requested. **(Timeliness)**

g. Staff members and practitioners involved in clinical or administrative review will not be given the incentive to make determinations that result in underutilization nor rewarded for issuing non-approval or non-certification determinations. **(Quality)**

h. During the interview, UnitedHealthcare reported that they have an emergency backup plan for critical members in the event of a natural disaster. The senior leadership conducts mock exercises, and the disaster plan is updated annually. Providers are contracted for after-hour service arrangements, e.g., online call staff and urgent care centers. **(Quality, Timeliness, Access to Care)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-27.

Table 4-27. Coverage and Authorization of Services

Weakness	EQRO Recommendation
a. UnitedHealthcare did not identify, define, and specify the amount, duration, and scope of services required to offer categorically needy and medically needy members that are sufficient to achieve its purpose.	Submit documentation.
b. UnitedHealthcare's policies did not address that the services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS.	Address the missing element and create/update the policies to describe how it meets the requirements instead of presenting the contractual requirements "as is."
c. UnitedHealthcare did not submit a policy to meet the criterion regarding protecting and allowing members the freedom to choose family planning services.	Submit documentation.
d. Policy, "Clinical Review Criteria," has two versions. The old version copied the MHD contract quoting sections about the requirements, such as: if an MCO requires a referral, assessment, or other requirements	Reconcile two versions of the policy, "Clinical Review Criteria," adopt the MHD's requirements and describe the process as applicable.

prior to the member accessing requested medical or behavioral health, such requirements shall not impede the timely delivery of the medically necessary service; and ensures uninterrupted medical supplies, oxygen, nutrition, and treatment regimens. The new version does not have any information that complies with the above-mentioned criteria.	
e. Documentation and adopting requirements from the MHD contract in UnitedHealthcare policies remains an issue. The policy, "Initial Clinical Review," has two versions. The old version quotes the requirements from the MHD contract, such as: if an MCO prior authorizes health care services, the MCO shall not subsequently retract its authorization after the services have been provided or reduce payment for an item or service (except under some circumstances-misinterpretation or omission of health information, contract termination, coverage termination); and MCO shall not deny physician requested continuing coverage of an inpatient hospital stay unless an alternative service is recommended by the MCO. The new version of the policy does not meet the requirements.	Reconcile two versions of the policy, "Initial Clinical Review," adopt the MHD's requirements and describe the process as applicable.
f. Approval or denial of non-emergency services, when determined by emergency room staff, shall be provided by the MCO within 30 minutes of the request for behavioral health services. UnitedHealthcare did not submit its policy decision timeframe for physical health-related non-emergency services.	Reconcile the two versions of the policy, "Initial Review Timeframes," and adopt the MHD's requirements for all prior authorization decisions.

Regulation V- Provider Selection.

Strengths.

a. Credentialing and re-credentialing policies and procedures comply with the requirements of determining and assuring all in-network providers are licensed by the state where they practice and are qualified to perform their services. UnitedHealthcare monitors participating licensed independent practitioners (LIPs) and facilities for complaints, potential quality concerns, or identified adverse events. Identified concerns will be tracked and resolved in accordance with UnitedHealthcare's policy. The Universal Credentialing Data Source form (Form UCDS) by the Council for Affordable Quality Healthcare (CAQH) has been adopted and used by UnitedHealthcare and their agents when credentialing or re-credentialing health care professionals in compliance with the MHD contract, section 2.18.8(c). **(Quality)**

b. UnitedHealthcare credentials and re-credentials for all in-network providers listed within the MHD contract, section 2.18.8(c), within 60 business days of applying. UnitedHealthcare has submitted data showing provider credentialing turn-around-time as 100% for each month in CY 2021. **(Timeliness)**

c. UnitedHealthcare monitors primary care physicians' compliance with advance directives through Medical Records Review (MRR). The MRR data, including advanced directives, are reviewed quarterly by the Quality Management Committee, and the results are included in the re-credentialing process, as applicable, to determine whether the provider is following the policies and procedures related to advanced directives. **(Quality)**

d. UnitedHealthcare requires all its subcontractors to make disclosures to UnitedHealthcare of complete information regarding ownership, financial transactions, and persons convicted of criminal activity related to Medicaid: 1) upon execution of the subcontract; 2) within 35 calendar days of any change in ownership; and 3) at any time upon request by UnitedHealthcare and the State for any or all of such information. **(Quality, Timeliness)**

e. UnitedHealthcare reviews state and federal reports, as well as publicly available health care entity reports, within 30 calendar days of their release to identify and exclude Participating LIPs who have had Office of Inspector General (OIG) sanctions on Medicare or Medicaid participation, General Services Administration (GSA) debarments, or other sanctions or restriction on their ability to practice. Providers must represent that they are licensed and certified under applicable state and federal statutes and regulations and are eligible to participate in the Medicaid program. **(Quality)**

f. The data for the newly credentialed providers attached to a new contract was loaded into the claim adjudication and payment system with a contractual timeframe of 10

business days (100% compliance). **(Timeliness)**

g. UnitedHealthcare does not make credentialing and re-credentialing decisions based on a licensed independent practitioner's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the licensed independent practitioner or facility specializes. UnitedHealthcare also does not discriminate in terms of participation, reimbursement, or indemnification against any licensed independent practitioner acting within the scope of the applicable license or certification under State law, solely based on the license or certification. Every request for proposal (RFP) managed by the Enterprise Sourcing & Procurement (ES&P) team targets the inclusion of at least one diverse supplier, where available. **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-28.

Table 4-28. Provider Selection

Weakness	EQRO Recommendation
a. No documentation was submitted about notifying the state agency of any denial of enrollment due to the results of the provider credentialing or re-credentialing process.	Submit documentation. (This is not the same as the quarterly report log fraud, waste, and abuse report log that UnitedHealthcare submitted.)
b. UnitedHealthcare's timeframe (5 business days) from credentialing to uploading the newly credentialed providers to the existing contract in the claims system was met only for four months in CY 2021. UnitedHealthcare's compliance was 78%-100% throughout the year.	UnitedHealthcare conducted a root cause analysis for the months the target was missed. UnitedHealthcare should adhere to the contractual timeframes at all times.
c. UnitedHealthcare's Missouri State Programs Regulatory Requirements Appendices for Medical and Non-Medical Subcontractors do not include a statement about including minorities in their company.	Update the appendices for the subcontractors communicating the policy statement on minority inclusion or provide a link to its webpage on Supplier Diversity-UHG.com.

Regulation VI- Confidentiality.

Strengths.

a. UnitedHealthcare policies and procedures address privacy and security requirements: minimum necessary; use and disclosure; business associates; authorizations; individual rights; privacy notice; complaints; and safeguards. The UnitedHealthcare's Corporate Privacy Office (CPO) head leads the HIPAA privacy compliance for UnitedHealthcare, including the development of enterprise-wide policies and procedures to safeguard the privacy of individuals' PHI consistent with federal and state laws and regulations, as applicable. **(Quality)**

b. UnitedHealthcare workforce members are responsible for safeguarding the privacy of PHI/electronic PHI: confidentiality of information concerning applicants and members of public assistance; 42 CFR Part 2, regarding confidentiality of substance use disorder member records; and records for adult and adolescent STDs and adolescent family planning services. **(Quality)**

c. All UnitedHealthcare employees receive mandatory privacy and security training at the beginning of their employment (within 30 days of joining the workforce) and at least annually. **(Quality)**

d. No disciplinary actions will be applied against a whistleblower Workforce Member (based on the fact that they were a whistleblower) or a workforce member who is a victim of a criminal act and Discloses PHI to law enforcement (subject to certain limitations). **(Quality)**

e. Use and Disclosure of PHI are permitted without authorization only for treatment, payment, and day-to-day UnitedHealthcare operations. Disclosures of an individual's PHI to government entities are mandated by law and do not require authorization or advance notification to an individual but may still require an accounting. However, the authorization exceptions do not apply to the uses and disclosures of psychotherapy notes and marketing. **(Quality)**

f. UnitedHealthcare Business Associate may aggregate PHI of more than one Covered Entity to conduct analyses for the provision of data aggregation services to each Covered Entity (or Business Associate on the Covered Entity's behalf), provided that the analyses are related to the Healthcare Operations of each such Covered Entity, and data aggregation services are authorized by the relevant Business Associate Agreement (BAA). **(Quality)**

g. The de-identified information that has been re-identified may not be disclosed or used except as permitted under the Privacy Rule and the Privacy Policy Manual for Disclosure and Use of PHI. **(Quality)**

h. UnitedHealthcare enters BAA based on HIPAA privacy and security requirements, with any vendor/subcontractor who will have PHI access. UnitedHealthcare may disclose PHI to a Business Associate and allow the Business Associate to create, receive, maintain, or transmit PHI on its behalf, provided it obtains satisfactory assurances that the Business Associate will appropriately safeguard the information. **(Quality)**

i. UnitedHealthcare shall provide an accounting of disclosures of PHI regarding an individual; and the access to the PHI in an individual's designated record set to the state agency by no later than five calendar days of request. **(Timeliness)**

j. UnitedHealthcare shall report to the state agency's Privacy Officer any security incident, breach, unauthorized use, or disclosure of PHI immediately upon becoming aware of such incident. A written description of the breach, the information compromised by the breach, any remedial action taken to mitigate any harmful effect of such incident or disclosure, and a proposed written plan of action for approval that describes plans for preventing any such future incidents, unauthorized uses or disclosures, will be provided within five calendar days of notice. **(Quality, Timeliness)**

k. Record retention policy for PHI under HIPAA is a minimum of six years from the date of creation or when it was last in effect, whichever is later. For CMS-regulated entities, such documentation must be retained for a minimum of 10 years. **(Timeliness)**

l. Marketing is not a permissible use or disclosure of PHI under HIPAA. It requires Member authorization (except for face-to-face communication by the Covered Entity or promotional gifts of nominal value provided by a Covered Entity to a member). For marketing communications made by UnitedHealthcare that require written authorization and involve direct or indirect remuneration to a UnitedHealthcare member from a third party, the authorization must state that such remuneration is involved. **(Quality)**

m. UnitedHealthcare shall indemnify the state agency from any liability resulting from any violation of the Privacy Rule or Security Rule or Breach arising from the conduct or omission of the MCO or its employee(s), agent(s), or subcontractor(s). **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-29.

Table 4-29. Confidentiality

Weakness	EQRO Recommendation
UnitedHealthcare did not have a policy to make its internal practices, books, and	UnitedHealthcare updated its policy, "Privacy and Confidentiality," after the

records, including policies and procedures and PHI, relating to the use and disclosure of PHI available to the state agency and to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the HIPAA Rules and the MHD contract within the timeframe of 10 calendar days.	preliminary review when PTM identified the noncompliance. The revised policy should be submitted to the MHD for approval.

Regulation VII- Grievance and Appeal System.

Strengths.

a. UnitedHealthcare's Government Appeals Operations (GAO) processes appeals and grievances submitted by members and their authorized representatives, including providers submitting on behalf of members. The Resolving Analyst (RA) is the staff person responsible for investigating appeals and grievances and compiling the electronic record. Oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. The RA assigned to the case on grievance and appeal is an individual not involved in the previous disposition and is not a subordinate of the individual who made the previous disposition. **(Quality)**

b. Written policies and procedures detail the operation of the grievance and appeal system and provide simplified instructions on how and when to file a grievance or appeal and to request a State Fair Hearing, the timing of the notice of adverse benefit determination, the time frame for standard service decisions (36 hours includes one business day) and extension (not more than 14 calendar days). Enrollees, a provider, or an authorized representative with the enrollee's written consent may request an appeal, file a grievance, or request a State Fair Hearing on behalf of an enrollee, with the exception that providers cannot request continuation of benefits. An enrollee can file a State Fair Hearing if an adverse benefit determination is upheld or the timeframe to resolve an appeal within 30 calendar days is exhausted. **(Quality, Timeliness)**

c. UnitedHealthcare has policies and procedures to comply with the timeframe of filing a grievance (any time), an appeal (within 60 calendar days of adverse benefit determination notice), and a State Fair Hearing (within 120 calendar days of notice of resolution of an appeal). UnitedHealthcare acknowledges receipt of each grievance and appeal in writing within 10 business days of receiving a grievance or appeal. **(Timeliness)**

d. Enrollees are provided any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. The assistance includes, but is not

limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with adequate TTY/TTD and interpreter capability. **(Quality)**

e. The member and the member's representative may request the member's case file free of charge, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UnitedHealthcare (or at the direction of UnitedHealthcare) in connection with the appeal of the adverse benefit determination. **(Quality)**

f. UnitedHealthcare complies with the timeframe for resolution of grievance (30 calendar days), appeal (30 calendar days), and expedited resolution for appeal (72 hours), and notices to the affected parties are provided. UnitedHealthcare does not take punitive or retaliatory actions against a member or provider supporting a member for filing an expedited appeal. **(Quality, Timeliness)**

g. UnitedHealthcare maintains the records for grievances and appeals in the Escalation Tracking System (ETS) in an accessible manner to the CMS and the MHD and submits logs for grievances and appeals each month in the format required by the MHD. The records are maintained for a minimum of 10 years. **(Quality, Timeliness)**

h. UnitedHealthcare is knowledgeable of its role after the final resolution of the appeal or State Fair Hearing. If the decision is against the enrollee, UnitedHealthcare may recover the cost of services furnished to the enrollee for the period appeal or State Fair Hearing was pending. UnitedHealthcare must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the adverse benefit determination. **(Quality, Timeliness)**

i. During the interview, UnitedHealthcare reported that the grievances filed in CY 2021 were 0.05-0.07 per 1000 members, and appeals were 0.03-0.05 per 1000 members, which was within their target (4 per 1000 members). The number of adverse benefit determination notices was 12252, out of which 204 (1.7%) were appealed. (Note: The data for comparison from the last year was not provided.) **(Quality)**

Weaknesses and Recommendations. Areas of concern and the recommendations to close the identified gaps are listed in Table 4-30.

Table 4-30. Grievance and Appeal System

Weakness	EQRO Recommendation
a. Even though the definitions of grievance, appeal, grievance and appeal system, inquiry, adverse benefit determination, and State Fair Hearing are accurately defined in the policies, the provider manual does not include an accurate definition of adverse benefit determination and appeal.	Update the provider manual with accurate definitions of adverse benefit determination, and appeal per 42 CFR 438.400.
b. The member flyer explaining the grievance and appeal system distributed to the members upon enrollment had incomplete and inaccurate information.	The flyer was updated after PTM identified the deficiencies in the preliminary review. PTM recommends that UnitedHealthcare submits the revised flyer for the MHD's approval and posts the MHD's approval date in the right lower corner of the flyer per the requirements of the MHD contract, section 2.14.6(e).
d. The policy, "Initial Adverse Benefit Determination Notices," did not address all the criteria required to be included in the notice of adverse benefit determination per 42 CFR 438.404.	UnitedHealthcare updated another policy, "Member Appeal, State Fair Hearing and Grievance," to comply with all the criteria required to be included in the notice of adverse benefit determination after PTM pointed out the deficiencies in the preliminary review. PTM recommends that the revised policy be submitted to the MHD for approval.
e. The policy, "Initial Adverse Benefit Determination Notices," states that a written notice of adverse determination includes the availability of peer clinical review before filing an appeal.	PTM noted that the provision of peer clinical review in the notice of adverse benefit determination is not in compliance with 42 CFR 438.404. The peer clinical review can be held before the notice is mailed to the member/provider and must not be included in the notice of adverse benefit determination. The policy and procedure must be updated.
f. Policies, "Initial Review Timeframes," acknowledged the requirements listed in this section by posting the MHD contract/CFR sections. Another policy, "Appeal Process and Record Documentation," has the same issue.	PTM recommends that UnitedHealthcare adopt the MHD contract/CFR requirements to create its policies and procedures.
g. The member handbook does not provide information on applying for a State Fair	Update the member handbook.

Hearing when UnitedHealthcare does not resolve an appeal within 30 calendar days (deemed Exhaustion of the appeal process).	
h. The provider manual has the following deficiencies/inaccuracies: • Definition of an appeal and State Fair Hearing. • All conditions in adverse benefit determination under which a provider on behalf of a member can file an appeal. • The time frame for filing under which benefit would continue pending an appeal or a State Fair Hearing during the review period.	UnitedHealthcare incorporated the timeframe for filing an appeal or State Fair Hearing under which benefits would continue after PTM identified the deficiency. The remaining information should be updated in the provider manual.

4.4.2 Improvement from previous year

Table 4-31 shows the degree to which UnitedHealthcare responded to PTM's recommendations from the previous year's EQR. PTM reviewed the documents to assess the non-compliant criteria per the CAP and the weaknesses identified in EQR 2021. The response was evaluated and categorized as High, Medium, and Low (Table 4-32), as defined in section 4.2.2 of this report.

Table 4-31. Score for Degree of Response						
Total	High	=	24	×2	=	48
	Medium	=	1	×1	=	1
	Low	=	5	×0	=	0
Numerator	Score Obtained					49
Denominator	Total Sections	=	30	×2	=	60
Overall Score= Medium						**81.7%**

Table 4-32. UnitedHealthcare's Response to Previous Recommendations

Recommendations	Action by UnitedHealthcare	Degree of Response
EQR 2021		
1. Disenrollment: Requirements and Limitations		
UnitedHealthcare updates its Medicaid Disenrollment Standard Operating	UnitedHealthcare did not submit the document.	**Low**

Procedure (SOP) by incorporating all the reasons a member can request disenrollment without cause.		
2. Enrollee Rights		
a. UnitedHealthcare should update its policy, MR-001 UHC MO Member Rights, to describe how UnitedHealthcare ensures Enrollee Rights. Primaris (PTM) suggested UnitedHealthcare survey members for the areas not addressed in the CAHPS survey to assess the extent to which the Enrollee's Rights are met. The providers should also be regularly educated on the state and federal requirements.	No action was taken.	**Low** Ensuring enrollee rights is not addressed. The same recommendation applies.
b. UnitedHealthcare post the member rights and responsibilities on their website under member resources so that members are aware of these even without reading the member handbook.	UnitedHealthcare has directed its webpage to the MHD website, where members' rights are displayed.	**High**
c. UnitedHealthcare update its policy, MO-MK001 Marketing Guidelines, with the font size requirement to "conspicuously visible size" of the taglines instead of "18 font size." UnitedHealthcare member materials should be readable at the sixth-grade level.	MO-MK001 Marketing Guidelines: page 5 No action was taken.	**Low** The policy is not updated. Large print is defined as a print size no smaller than 18 points. The same recommendation applies.
d. UnitedHealthcare must explore different ways to notify changes impacting members at least 30 calendar days before the effective day of change and implement them.	MR-001 UHC MO Member Rights (revised): page 2 UnitedHealthcare updated its policy to include various member engagement platforms. Members will also be informed of changes via the website and Health Talk Newsletters. (uhccommunityplan.com)	**High**

	Here For You-MO (Flyer informing Medicaid Expansion)	
e. UnitedHealthcare must update its member handbook to meet all the 48 items listed in the MHD contract, section 2.12.16, even though the MHD provides a template.	MO Member Handbook 2022	**Low** The same recommendation applies.

Findings: Out of 48 criteria required in the member handbook per the MHD contract 2.12.16, nine were "Partially Met," and three were "Not Met" during EQR 2021. PTM re-reviewed the revised 2022 member handbook available at UnitedHealthcare's website (downloaded on Apr 15, 2022) and found that only three of nine "Partially Met" criteria were addressed. Thus, six criteria remain "Partially Met," and three remain "Not Met." (Alphabets used below refer to the criteria from EQR 2021 Compliance Report). The "Partially Met" criteria are as follows:

h. Information on how and where members can access benefits provided by the State is not mentioned.

i. A description of all available services outside the comprehensive benefits package, including information on where and how members may access benefits not available under the comprehensive benefit package, is not stated.

t. All the conditions under which an enrollee can disenroll with or without cause are not listed.

a6. Information on how to access behavioral health when in crisis is not indicated.

a.18. In reference to the Advance Directives, UnitedHealthcare did not include a statement on "any limitation regarding the implementation of advance directives as a matter of conscience" as required per the MHD contract.

a.20. Information on how a member can request to obtain a free copy of their medical record annually is not provided.

The "Not Met" criteria are as follows:

k. A description of all prior authorization or other requirements for treatments and services is missing.

q. How a member with a life-threatening condition, disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, may request access to a specialty care center and the procedure by which such access may be obtained.

y. Information about the disease management program is not provided.		
f. UnitedHealthcare must update its policy, Rally-Online Directory, to include all the requirements about their network providers. The provider directory (PDF version) submitted to Primaris (now PTM) should be updated to consistently reflect all the criteria for every provider in the network per the 42 CFR 438.10h and the MHD contract, section 2.12.17. UnitedHealthcare should educate its providers about the contractual requirement for submitting their information to UnitedHealthcare.	Rally-Online Directory Provider Directory (Introduction) Snapshot from an online provider search tool showing URL and Interpreter, American Sign Language availability Provider Directory Central Missouri Snapshots (website/URL, panel status, footnote)	**High** The policy "Rally-Online Directory" does not incorporate a field "URL/Website" for the providers. However, this information is presented in the online and PDF version of the provider directory. Information on the panel status is not available in the PDF version for all providers, even though it is online. Information on linguistic capabilities is not stated for all the providers. However, a footnote states that all providers accept new patients and are proficient in English unless noted otherwise.
g. UnitedHealthcare should update its policy, "Provider Directory Creation and Distribution," to clearly state what they mean by "processing the request within 48 hours." UnitedHealthcare is required to mail the directories to the members within 48 hours of their request.	Provider Directory Creation and Distribution: page 2 The policy is updated.	**High**
h. UnitedHealthcare should consider providing a notification for their members on the website about requesting a paper directory.	UnitedHealthcare informed PTM that the information is presented	**High** PTM confirmed the information.

	in the member handbook posted on the website.	
i. The only means of disseminating information to the members regarding Enrollee Rights, per 42 CFR 438.10, is via a member handbook. UnitedHealthcare should consider using its website to disseminate information about access to member-related information in a paper format. Newsletters, flyers, and blogs are suggested ways of communicating information on Enrollee Rights.	UnitedHealthcare's webpage has linked the information to the MHD website. Furthermore, they will provide the links in the summer newsletter.	**High**
3. Emergency and Post-stabilization Services		
a. UnitedHealthcare must consistently update definitions of an emergency medical condition, emergency services, and post-stabilization services in its documents. UnitedHealthcare should update the policy, 2020F7012C Reimbursement, on the definition of an emergency medical condition. Also, update the definition of "emergency services" in the member handbook.	MO Member Handbook: page 85 The member handbook is not revised to update the definition of the emergency medical condition, and the policy is not submitted.	**Low** Same recommendation applies
b. UnitedHealthcare must update the Provider Manual that states, "After the member has received emergency care, the hospital must seek approval within one hour for pre-approval for more care to make sure the member remains stable." The duration for approval must be updated to 30 minutes instead of one hour.	2022 Care Provider Manual: page 32 The provider manual on the website is updated.	**High** PTM confirmed the information.
c. UnitedHealthcare must provide documentation on the payment agreement with its providers on emergency and post-stabilization services.	MOUM001 Emergency Care and Post Stabilization: page 3 MO Medicaid State-Specific Payment Appendix: pages-5, 6	**High** All documents comply with the requirements.

	Single Case Letter of Agreement: page 5	
4. Subcontractual Relationships and Delegation		
a. UnitedHealthcare explicitly and consistently writes in all the subcontracts that UnitedHealthcare shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract. UnitedHealthcare must have a policy, guidelines, or Master Service Agreement that meets this criterion.	MO State Program(S) Regulatory Requirements Appendix: page 4	**High** The document is compliant.
b. UnitedHealthcare must update all their contracts other than the Dental Benefit Providers' contract, with the requirements set under the MHD contract, section 3.9.6. (The MHD contract, section 3.9.6, requires an MCO to specify the delegated activities, obligations, and related reporting responsibilities in the subcontract or written agreement.)	Children's Mercy Integrated Care Solutions, Inc: page 36 CareCore National, LLC (Participating Plan Addendum # 28): pages-3, 7 Medical Transportation Management (MTM): pages-3, 4 March Vision Care Group, Inc. Exhibit B/F: pages 21, 53 Rose International, Inc: pages-2, 3, 22	**High** All the documents are compliant with the requirements.
c. UnitedHealthcare should update its contract with Rose International, Inc. and include Missouri Medicaid on the "right to audit."	MO State Program(S) Regulatory Requirements Appendix: page 4 UnitedHealthcare submitted an Appendix specific to MO State Program and stated that UnitedHealthcare will amend identified vendors' contracts to	**High** The document complies with the requirement. PTM recommends that UnitedHealthcare ensures this Appendix is incorporated in the subcontract with Rose International, Inc.

	include the Appendix as needed to comply.	
d. UnitedHealthcare should consistently update the duration of record retention for 10 years at all places in all subcontracts.	MO State Program(S) Regulatory Requirements Appendix: page 4 UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts.	**High** PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with all subcontracts.
e. UnitedHealthcare must update the Rose International, Inc., Master Services Agreement, and March Vision Care Group, Inc. contract to ensure the MHD consistently is indemnified, saved, and held harmless from and against all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract.	MO State Program(S) Regulatory Requirements Appendix: page 3 UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts.	**High** PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with Rose International, Inc, March Vision Care Group, Inc., and all other subcontractors.
f. UnitedHealthcare should update its subcontract with Rose International, Inc. to indemnify the State in case of any dispute between UnitedHealthcare and its providers. CareCore National, LLC's contract should be updated to mention that the State will not be involved in any dispute between UnitedHealthcare and the subcontractor.	MO State Program(S) Regulatory Requirements Appendix: page 3 UnitedHealthcare informed PTM that the revised Appendix will be added to all the subcontracts.	**High** PTM recommends that UnitedHealthcare ensures this Appendix is incorporated with Rose International and all other subcontractors.
5. Practice Guidelines		
UnitedHealthcare informs its members via any medium, e.g., member handbook, mailers, newsletters, about the availability and access to evidence-based practice guidelines.	MO-AMC-Medicaid-Newsletter-Spring-2022-EN.pdf A member newsletter is posted on the website, informing them about CPGs.	**High**
6. Health Information Systems		
a. UnitedHealthcare must explain/describe its process of how the	Escalation Tracking System: page 2	**High**

health information system provides information on Utilization management (UM), claims, grievances and appeals, and disenrollment.	MO_MIS001 Management Information System (MIS): Pages-1 to 3 Encounter Data Completeness, Accuracy, and Timeliness: page 1 Manual Updates in Facets CSP: pages 1 to 4 MO-ENR-01 Disenrollment Effective Dates: page 5 Data Entry Medical SOP (Medical Claims into Facets): page 8 CSP Facets Source (Systems Access, Transactions Processing, Adjustment Processing Guidelines): page 71	Documents meet the requirements.
b. UnitedHealthcare must have documentation about how its claims processing and retrieval system detects fraud and abuse necessary for program integrity, oversight, and administration.	Compliance Committee Report (CCR) (Jun-Jul-Aug 2021) Encounter Data Completeness, Accuracy and Timeliness: page 1 CSP Facets Source: pages-54, 55 Anti-Fraud, Waste, and Abuse Program 2022-2023: pages-3, 5, 6 UnitedHealthcare Compliance Program: page 8	**High** Documents meet the requirements.

c. UnitedHealthcare must have Electronic Claims Management (ECM) policies and provide phone-based capabilities to obtain claims processing status information.	Provider IVR High-Level Call Flow (embedded in policy-MO PS-001) Optum Pay UHCprovider.com: pages 3 to 5 Health Insurance Claim Form 1500/UB-04 Standard Companion Guides-Professional/Institutional (Embedded in policy MO_MIS001 MIS)	**High** Documents meet the requirements.
d. Adherence to Key Transaction Standards: UnitedHealthcare must have policies and procedures to address HIPAA standards related to claims processing and electronic transaction standards.	Standard Companion Guides-Professional /Institutional (embedded in policy MO_MIS001 MIS): page: 14 EDI Claim Edits (embedded in policy MO_MIS001 MIS): pages-1 to 6	**High** Documents meet the requirements.
e. UnitedHealthcare must have policies and detailed processes/procedures describing their HIS System flow charts' functional/operational aspects. Also, they must address how they verify the timeliness of the reported provider data and collect data from providers in standardized formats, including secure information exchanges and technologies utilized for the MHD quality improvement and care coordination efforts.	Electronic Communication Gateway (ECG) Overview: pages-1, 2 Standard Companion Guides-Professional (embedded in policy MO_MIS001 MIS): pages-8, 9 Encounter Data Completeness, Accuracy, and Timeliness: pages-1, 2 CSP Facets Source: pages 35 to 90	**High** Documents meet the requirements.

f. UnitedHealthcare must implement an Application Programming Interface (API) as specified in 42 CFR 438.242, in reference to 42 CFR 431.60 and 431.70. EQRO will evaluate the requirements for patient access API and provider access API, in EQR 2022, as a follow-up item.	API Procedure: pages-1, 2 API is developed and implemented.	**High**
g. UnitedHealthcare must have a detailed description of its process and data elements captured to identify the providers delivering services or items to enrollees.	EDI Claim Edits (embedded in policy MO_MIS001 MIS): pages-1 to 6 Encounter Data Completeness, Accuracy, and Timeliness: pages-1, 2	**High** Documents meet the requirements.
h. UnitedHealthcare should have a policy and submit evidence to show that their encounter data submitted to the MHD includes the allowed and paid amounts per 42 CFR 438.818.	Encounter Data Completeness, Accuracy, and Timeliness: page 2 Monthly Encounters Self-Reporting (Excel-July 2021)	**Medium** The policy complies with the requirement; however, the encounter data submitted to the MHD includes only the paid amounts. The MHD's Encounter Data process is not yet updated to capture and submit the allowed amounts.
i. UnitedHealthcare must submit sufficient documentation to show that encounter data submitted to the MHD comply with standardized Accredited Standards Committee (ASC) X12N 837 and has implemented version 5010 transaction set.	Encounter Data Completeness, Accuracy, and Timeliness: page 2 Standard Companion Guide (embedded in policy MO_MIS001 MIS)	**High** Documents meet the requirements.
EQR 2020 (Action item pending)		
Grievances and Appeals: UnitedHealthcare reported Member	Addendum QAPI Non-Behavioral Health	**High**

Appeals under categories such as Quality of Care, Attitude/Service, and Quality of Practitioner Office Site. EQRO finds these categories not aligned with the definition of adverse benefit determination & appeals per 42 CFR 438.400. EQRO recommends that UnitedHealthcare seek written clarification on expectations from the MHD. UnitedHealthcare should update data in the 2019 QAPI report and comply with the MHD's instructions for future reporting.	Member Appeals Data 2019-2021 (snapshot)	PTM noted that categories for Appeals are rectified in the snapshot submitted. Details will be evaluated next year when the regulation (QAPI) is reviewed.

4.5 Recommendations for MCOs

PTM recommends that Home State Health, Healthy Blue, and UnitedHealthcare submit their updated documents to address all the weaknesses listed for regulations in sections 4.2.1, 4.3.1, and 4.4.1, respectively. Additionally, the MCOs must address "Low" and "Medium" response criteria from the previous year's recommendations (Tables 4-13, 4-23, and 4-32, as applicable to the MCOs). The MCOs must proactively develop their policies and procedures for all the regulations covered in the compliance review and not merely post snapshots/tabulate contents "as is" from the MHD contract and CFR.

5.0 REVIEW OF CARE MANAGEMENT PROGRAM

5.1 Objective and Technical Method

PTM reviewed Home State Health, Healthy Blue, and UnitedHealthcare's CM programs to determine the key drivers (strengths) and issues (weaknesses) per the EQRO contract with the MHD. The MHD required PTM to evaluate three CM focus areas in the EQR 2022:

- Individuals in foster care, receiving foster care or an adoption subsidy, or other out-of-home placement (hereinafter referred to as Foster Care CM).
- Individuals with Autism Spectrum Disorder (Autism CM).
- Children with Elevated Blood Lead Levels (EBLLs CM).

Figure 5-1. Case Management Knowledge Framework[3]

[3] https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

"Case management" is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs (Figure 5-1). It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the 'Triple Aim,' of improving the experience of care, improving the health of populations, and reducing per capita costs of health care" (reference: Commission for Case Manager Certification). (Note: The term "case management" is replaced by "care management" in the MHD contract.)

The guidelines provided in the MHD contract (version: Oct 1, 2021), section 2.11.1, Member Care Management, and section 4.7.4, Care Management, were utilized for creating evaluation tools for the CM review. The MCOs' CM programs were evaluated under the following headings:

1. Policies and Procedures Review: Per the MHD contract, section 2.11.1(c)(5), the MCOs must have policies and procedures for the CM programs. PTM reviewed all the documents submitted by Home State Health, Healthy Blue, and UnitedHealthcare and reported the results in Tables 5-1, 5-9, and 5-17, respectively.

2. Medical Record Review (MRR): PTM assessed the MCOs' ability to make all pertinent medical records available for review. All three MCOs submitted a list of members in care management in CY 2021 for the three focus areas. PTM selected a sample of 30 medical records (sample size 20 and 50% oversample for exclusions and exceptions) from each focus area. A simple random sampling methodology was utilized for drawing samples (reference: CMS EQR protocols, Appendix B). PTM requested the MCOs to upload all 30 medical records electronically at PTM's secure file upload site (AWS S3 SOC 2).

Evaluation tools (Excel workbooks) were created to capture information from medical records, which included, at a minimum: referrals; assessment; medical history; psychiatric history; developmental history; medical conditions; psychosocial issues/stressors; legal issues; care planning; lab testing; progress notes/follow-up; monitoring of services and care; coordination and linking of services; the transition of care after hospitalization; transfers; and discharge plans; and case closure.

Inter-Rater Reliability (IRR): The PTM team met weekly throughout the CM review to assess the degree of agreement in assigning a score for compliance with the evaluation tools. Findings from all cases (medical records) of Autism CM and EBLLs CM were reviewed, and the discrepancies were reconciled to achieve 100% IRR. A different auditor reviewed ten percent of medical records from Foster Care CM. PTM scored 100% exceeding its target of 95% IRR.

The following criteria were used for inclusions/exceptions/exclusions of medical records in the study sample:

Inclusion Criteria:

- Foster Care CM

Anchor date: Member must be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Based on eligibility criteria in the MHD contract (Category of Aid-COA 4).
Continuous enrollment: No break in enrollment for more than 45 days[4] with the MCO.
Event/Dx: ICD-10-CM-Z62.21/Z02.82 (must not be in CM in CY 2020).

- Autism CM

Anchor date: Member must be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Children at least 18 months of age.
Continuous enrollment: No break in enrollment for more than 45 days with the MCO.
Event/Dx: ICD-10-CM-F84.0 (must not be in CM in CY 2020).

- EBLLs CM

Anchor date: Member must be enrolled in the CM in CY 2021 for a minimum of one quarter.
Age: Children at least one-year-old during the measurement year.
Continuously enrolled: No break in enrollment for more than 45 days with the MCO.
Event/Dx: A venous blood lead level of 10 ug/dL.

Exclusion Criteria: Failure of initial contact with the member despite exhausting all means to contact a member per the MHD contract 2.11.1(f).

Exceptions: The member does not require care management on medical grounds/criteria.

3. Evaluation of Care Plan: The MHD contract 2.11.1(e) provides guidelines for the "care plan." PTM verified all the components of the care plans the MCOs created for each member included in the sample study for the medical record review.
All care plans were required to address the following: use of clinical practice guidelines (including the use of CyberAccess to monitor and improve medication adherence and prescribing practices consistent with practice guidelines); use of transportation, community resources, and natural supports; specialized physician and other practitioner care targeted to meet member's needs; member education on accessing services and assistance in making informed care decisions; prioritized goals based on the assessment of the member's needs that are measurable and achievable; emphasis on prevention, continuity of care, and coordination of care. The CM programs shall advocate for and link

[4] Days refer to "calendar days" unless specified as "business days" throughout this report.

members to services as necessary across providers and settings; and reviews to promote the achievement of CM goals and use of the information for quality management.

4. Site Interview: PTM conducted virtual site meetings with UnitedHealthcare on July 26, 2022; Home State Health on July 27, 2022; and Healthy Blue on July 28, 2022, to assess the following:

- The staff's knowledge of the MHD contract and requirements for CM-The guiding principle for CM is that the resources should be focused on people receiving the services they need, not because the service is available.
- The focus of CM services on enhancing and coordinating a member's care across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by members/families with complex issues; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative quality, health, and cost impact; and creating opportunities and systems to enhance outcomes.
- Clarifications from the preliminary findings during the desk review of policies and procedures and medical records carried out from Jun-Aug 2022.

5.2 Findings, Analysis, Conclusions, and Recommendations: Home State Health

CM Data for CY 2021: PTM obtained the following CM data and the schematic diagram (Figure 5-2) showing the CM process from the Home State Health.

Medicaid Managed Care members enrolled (year-end) = 299,237
Eligible population identified for CM = 23,113
Number of members identified for CM in the focus areas/enrolled =
Foster Care: 856/75
Autism: 212/131
EBLLs: 495/98
CM staff available (Total) = 62
Foster Care: 3
Autism/Behavioral Health: 14
EBLLs: 2
Average case load = 77 (maximum 107)

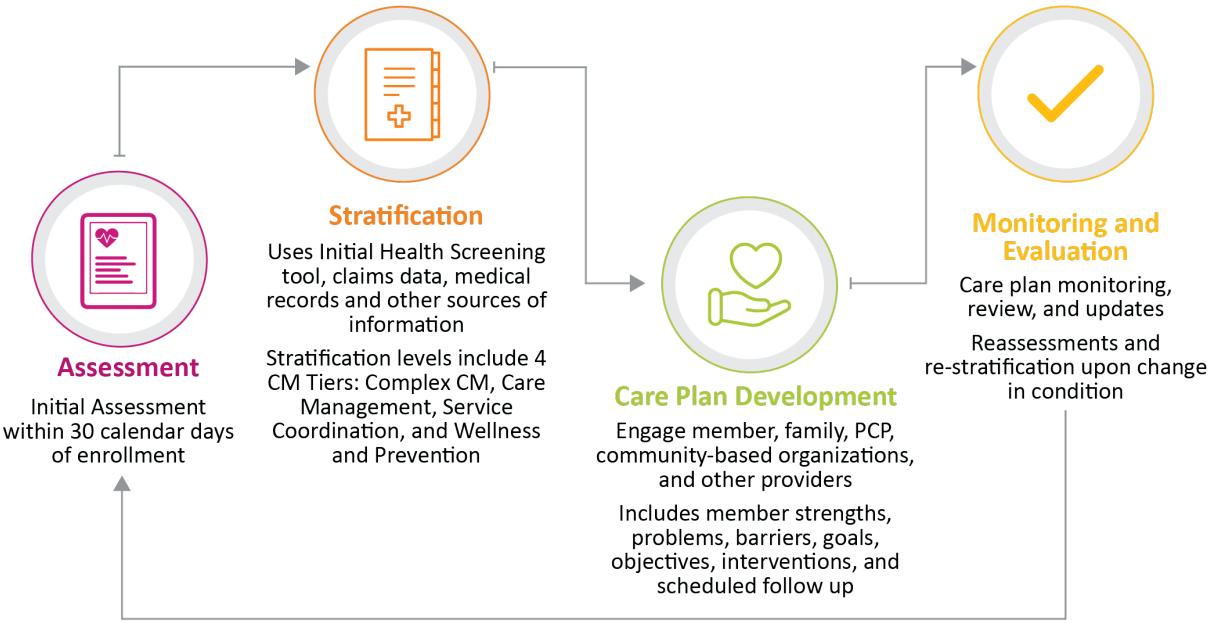

Figure 5-2. CM Process Flow Chart (Source: Home State Health)

Findings

Policies and Procedures Review

Home State Health submitted the following policies and procedures (Table 5-1). Upon review, PTM assigned a score of Met (), Partially Met (), or Not Met ()based on the requirements mandated by the MHD contract. (Note: Met/Not Met Definitions are adopted from CMS EQRO Protocol 3.)

Table 5-1. Policies and Procedures Review

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
1. A description of the system for identifying, screening, and selecting members for CM services.		MO.CM.01 Case Management Program Description.
2. Provider and member profiling activities.		MO.UM.01.03 Medical Management, Quality Improvement Program Evaluation 2021.
3. Procedures for conducting provider education on CM.		MO.CM.01 Case Management Program Description.

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
4. A description of how claims analysis will be used.	●	MO.CM.01 Case Management Program Description.
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in developing the care plan.	●	MO.CM.01 Case Management Program Description.
6. A process to ensure integration and communication between physical and behavioral health.	●	MO.CM.01 Case Management Program Description.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●	MO.CM.01 Case Management Program Description.
8. A process to ensure that care plans are maintained and updated as necessary.	●	MO.CM.01 Case Management Program Description.
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●	MO.CM.01 Case Management Program Description.
10. Timeframes for reevaluation and criteria for CM closure.	●	MO.CM.01 Case Management Program Description.
11. Adherence to applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●	MO.CM.01 Case Management Program Description.
12. A mechanism for feedback from youth in foster care or recently out of care and guardians/foster parents to inform processes and the healthcare visit schedule followed by the care managers for the individuals in foster care.	●	MO.CM.01 Case Management Program Description, Foster Care Playbook
PTM Comments	Home State Health is fully compliant. Nil recommendations.	

Medical Record Review

Table 5-2 summarizes the medical records included in the study for each CM focus area.

Table 5-2. Medical Records in the Sample Study

	Foster Care CM	Autism CM	EBLLs CM
Sample size/oversample	20	20	20
Exclusions	0	0	0
Medical records reviewed	20	20	20
Cases closed/goals met	9	6	5
Active cases (in progress)*	4	5	11

Table 5-3 identifies medical records' compliance with the criteria required in the MHD contract, as applicable to all three CM focus areas.

Table 5-3. Compliance (%) with CM Criteria

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Placement in Foster Care	40	N/A	N/A
Referral/Notification (State)	10	N/A	N/A
Referral/Notification (all sources)	*100	100	100
Initial screening within 72 hours of placement (within 24 hrs. for younger, chronic condition (by provider)	0	N/A	N/A
Initial Blood Lead Level	N/A	N/A	100
Offer CM (Assessment) within 30 days of notification from the State (new member)*	50		
Offer CM (Assessment) within 30 days or within the contractual timeframe for EBLLs from any source notification	70	90	5
Medical history	100	100	95
Psychiatric history	100	100	90
Developmental history	95	100	90
Psychosocial/Trauma history	100	100	90
Dental health	70	N/A	N/A
Legal issues	100	100	100
Education needs	100	N/A	N/A
Immunization history	100	N/A	N/A
Follow-up assessment in 60-90 days of placement (by a provider)	0	N/A	N/A

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Health Encounters-three in the first three months of foster care (all ages)-by a provider	0	N/A	N/A
Assessment within 30 days of discharge from hospital or rehab. facilities after readmission or stay of more than two weeks or three Emergency Department (ED) visits in a quarter/within five business days of admission to a psychiatric hospital or substance use treatment program	73	47	N/A
Confirmatory venous lead level within the contractual timeframe	N/A	N/A	100
Family encounter#	N/A	N/A	40
Follow up Family encounter#	N/A	N/A	68
Care plan	100	100	95
Care plan updated	100	100	100
Sharing health information with birth parents, guardians, attorney, court, and school/involved in the care plan	100	100	95
Progress notes (follow-up)	100	100	100
Lab tests/follow-up tests within timeframes for EBLLs	100	N/A	65
Provider treatment plan	100	90	60
Transfer	100	100	100
Monitoring services and care, medication adherence	100	100	95
Coordination and linking of services	100	100	95
Behavioral health services availed	100	N/A	N/A
Discharge plan	44	40	22**
PCP notification of case closure	56	7	56**
Member closure letter	N/A	N/A	56**
Aggregate Score	**76**	**87**	**80**

Red highlighted figures (score < 75%) indicate areas for improvement.

*For informational purposes, not included in calculating the aggregate score.

**Small denominator (9 cases) as cases are not closed for UTC per the MHD's instructions.

Telephonic encounters replaced face-to-face encounters due to the Covid-19 pandemic.

Evaluation of Care Plan

Home State Health met all the contractual requirements for creating a care plan based on the MHD contract, 2.11.1(e), listed earlier in this report (section 5.1). The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close the gaps. The care plan was reviewed at least quarterly; however, the frequency varied per the level of risk stratification. The care managers explained the CM rationale and relationship, the circumstances under which the information can be disclosed to third parties, and the complaint process. PTM did not have any issues to report.

5.2.1 Quality, Timeliness, and Access

Strengths. PTM concluded the following strengths from the MRR and staff interviews. (Domain: Quality, Timeliness, and Access to Care).

- Detailed care plan per clinical practice guidelines to include all aspects of care, e.g., immunization, medication adherence, lab tests, and transportation services. (CyberAccesssm is State's web-based, HIPAA-compliant tool that allows Home State Health to view drug utilization information in near real-time and pharmacy claims data extracts.)
- Monitoring, coordinating, and linking services with community resources, e.g., homestatehealth.auntbertha.com and the Home State Health app.
- Educating members on PCP, Urgent Care vs. ED Utilization, Rewards card, dental and vision services, transportation services, and Nursewise (24 hours Nurse Advice Line).
- Providing information about psychiatrists and counselors. Tracking and helping in scheduling appointments with the providers.
- Training care managers regarding linguistic and cultural competency.
- Provider engagement by sharing care plan as evident in Foster Care and Autism CM.

Weaknesses. PTM analyzed the MRR results and categorized the issues (weaknesses) in the domain of Quality, Timeliness, and Access to Care as follows (Tables 5-4 to 5-6). PTM provided recommendations for improving each issue.

Table 5-4. Foster Care CM Review: Weaknesses and Recommendations

Foster Care CM Weakness	Recommendation
1. Criterion: The date of placement of a child in Foster Care. **(Timeliness)** Home State Health did not know this information for 60% of cases.	Home State Health must work with the MHD* and Children's Division to receive the information on the placement of a child in COA 4

Foster Care CM Weakness	Recommendation
Home State Health informed PTM that the State did not provide the placement dates.	for effective CM (tracking initial screenings and health encounters by the providers).
2. Criterion: Referral/Notification dates. **(Timeliness)** The State notifications were captured by the Home State Health for 10% of cases even though they received 834 files from the State daily. The referral sources to initiate the outreach to the members were mainly internal notifications from Utilization Management reports.	Home State Health should maintain an accurate record of State notifications (834 files) about COA 4 members and start outreaching them for timely assessing the needs of COA 4 members.
3. Criteria: Initial screening within 72 hours/within 24 hours of placement for younger/preverbal children (by the providers); three encounters within the first three months of placement; and follow-up health assessment within 60-90 days of placement. **(Timeliness)** Home State Health did not track these criteria as the placement date was unavailable. Also, Home State Health informed PTM that they were not required to track and report these criteria to the MHD from the last quarter of CY 2021. (An MHD e-mail communication dated Oct 19, 2021, was submitted reporting these criteria were not required).	Home State Health and the MHD* must work towards addressing these three criteria. The MHD* must amend its managed care contract, section 2.11.1(d)(3) if the MHD does not require Home State Health to report on these criteria.
4. Criterion: Comprehensive assessment within 30 days of notification/enrollment. **(Timeliness)** Home State Health complied with the timeframe for 70% of cases when they received a notification from any referral source. Home State Health's compliance for assessing the Foster Care members following the State notifications was for 50% of cases (1 of 2 cases-small denominator).	Home State Health must initiate its CM activity immediately upon notification from the State on the 834 file-COA 4 eligibles.
5. Criterion: Assessment. **(Quality)** Home State Health assessed its enrollees' dental health needs only for 70% of cases. Trauma history was limited to merely asking about scary or upsetting things that happened to the member or family.	The columns in the assessment should not be left blank even if the caregivers were unwilling to provide the information. The outcome of the encounter with the caregivers should be documented. Detailed

Foster Care CM Weakness	Recommendation
PTM acknowledged that dental education was a part of a care plan for all CM members. PTM noted that Home State Health captured the start date of an assessment as the date on which a care manager began an outreach to a member. There were several unsuccessful attempts before a CM assessment was conducted.	trauma history should be elicited. The assessment's start date should be when a member is available for an assessment.
6. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** Home State Health was compliant for 73% of cases. The post-discharge assessment was not conducted for the remaining members due to unable to contact (UTC).	Home State Health should have a system of inpatient admission and discharge notifications from its providers so that timely post-discharge assessments can be conducted. A member's contact information must be obtained during the member's hospital stay. The MHD* must notify Home State Health about IP admissions and discharges in real-time so that Home State Health can outreach the caregivers for post-discharge assessment within the contractual timeframe.
7. Criterion: Case Closure-Lost Opportunities **(Access to Care)** Home State Health did not complete CM services, including discharge planning, in 56% of cases as they were UTC the members or members refused CM. PTM noted that the cases were closed as "goals met" without discharge planning and contacting the members (2 of the 7 UTC cases).	Maintain an accurate record of member contact numbers and motivate the members by demonstrating the value of the CM program. This is key to successful care coordination. PTM recommends closing no case before three months of unsuccessful outreach attempts.** Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other

Foster Care CM Weakness	Recommendation
	providers and programs and visit members' homes before closing a case for UTC.
8. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health notified providers in 56% of cases about the case closure/goals met.	A written notification to the PCPs must be provided to comply with the requirements. Staff must be trained to document the date of communication with the PCPs in the medical records.

*Recommendations apply to the MHD.

**Adapted from the MHD contract, section 2.12.10 (d): The health plan shall make its best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

Table 5-5. Autism CM Review: Weaknesses and Recommendations

Autism CM Weakness	Recommendation
1. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** Home State Health complied for 47% of cases, as applicable. There was no post-discharge assessment or a delay in assessment for the remaining cases.	Home State Health's Hospital Care Transition (HCT) team should coordinate with the utilization management team and care managers for the discharge dates and latest member contact information. The HCT team should educate the members on the significance of CM to motivate participation. The care managers should be trained to promptly outreach the members for a post-discharge assessment or an assessment within five business days of admission to a psychiatric hospital as applicable.
2. Criterion: Case Closure-Lost Opportunities. **(Access to Care)** Home State Health could not complete CM services, including discharge planning, in 60% of cases due to UTC.	Maintaining an accurate record of member contact numbers and motivating members by demonstrating the value of the CM program is the key to successful care coordination.

	PTM recommends closing no case before three months of unsuccessful outreach attempts. Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
3. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health notified providers in 7% of cases about the case closure/goals met.	A written notification to the PCPs must be provided about case closure, the reason for closure, and the member's condition at the time of discharge. The staff must be trained to document the date of communication with the PCPs in the medical records.

Table 5-6. EBLLs CM Review: Weaknesses and Recommendations

EBLLs CM Weakness	Recommendation
1. Criterion: Offer CM and complete an assessment within time frames for blood lead levels.* **(Timeliness)** The assessment was conducted for 85% of cases, but timeliness was achieved only in 5% of cases.	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers should obtain a date and time for future communications on initial contact.
2. Follow-up lab testing within the contractual time frame.** **(Timeliness)** All members had a follow-up blood lead level test. However, only 65% of members were tested within the contractual timeframe.	Same Recommendation as above.
3. Criteria: Family encounter (Face-to-Face/Telephonic) within two weeks of confirmatory venous blood lead level and second encounter within an interval of three months. **(Quality and Timeliness)** First and the second family encounters (telephonic) were completed timely in 40% and 68% of cases, respectively, to provide lead poisoning education,	Same Recommendation as above.

family/member assessment, develop a care plan, deliver care manager's name and phone number, assess member's progress, and reinforce education and medical regimen. Both encounters were made in almost all cases (19 of 20), but they were delayed due to several UTC attempts.	
4. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** Home State Health followed the requirements only in 25% of cases.	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members. The care managers must be trained to document the requirements in the medical records.
5. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** A letter about member enrollment in the CM program and a copy of the care plan were shared with the providers in 60% of cases.	Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records.
6. Criterion: Case Closure-Lost Opportunities **(Access to Care)** Home State Health did not complete the CM services, including discharge planning, in 78% of cases due to UTC.	Maintain an accurate record of member contact numbers and motivate them by demonstrating the value of the CM program. This is the key to successful care coordination. PTM recommends closing no case before three months of unsuccessful outreach attempts.** Additionally, Home State Health must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.

7. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Home State Health submitted evidence of notification to the providers in 56% of cases about the case closure/goals met.	A written notification to the PCPs must be provided about case closure, the reason for closure, and the member's condition at the time of discharge. The staff must be trained to document the date of communication with the PCPs in the medical records and save a copy of the letter sent to the providers.
8. Criterion: A member closure letter must include the date of discharge, the reason for discharge, lab results, member status, exit counseling (telephone number for member assistance, and the status of care plan goal completion. **(Quality, Access to Care)** Home State Health submitted evidence of notification to the members about the date of discharge, lab results, medical condition, and exit counseling in 56% of cases.	The care managers must be educated to comply with the MHD contract, section 2.11.1(e)(5). They must send a case closure letter to the member, save a copy as evidence, and document it in the medical records.

*EBLL: 10 to 19 µg/dL within one to three (1–3) business days; 20 to 44 µg/dL within one to two (1–2) business days; 45 to 69 µg/dL within twenty-four (24) hours; 70 µg/dL or greater – immediately.
**Follow up: 10-19 µg/dL – two to three (2-3) month intervals; 20-70+ µg/dL – one to two (1-2) month intervals.

5.2.2 Improvement from previous year

CM review was not assigned during the previous year (EQR 2021). Therefore, there were no recommendations. However, in EQR 2020, EQRO provided recommendations for Behavioral Health CM that apply to Autism CM. Table 5-7 shows the degree to which Home State Health responded to EQRO's recommendations from EQR 2020. PTM evaluated the actions taken by Home State Health and categorized them as High (Two points), Medium (One point), and Low (Zero points), defined in the previous section 4.2.2 of this report.

Table 5-7. Home State Health's Response to Recommendations from EQR 2020

Recommendation	Action by Home State Health	Comment by EQRO
1. CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.	Home State Health's performance increased marginally from 45%	**Low** The issue persists. PTM has provided recommendations

	(EQR 2020) to 47% (EQR 2022).	in Table 5-5 (issue 1).
2. The care plan should be shared with the providers and informed about how they can provide input or change the care plan.	This criterion was not evaluated in EQR 2020 per the MHD's instructions. In the EQR 2022, compliance is 90% for Autism CM.	**High** Home State Health should apply the same efforts to all focus areas. EBLLs CM is scored at 60% for the same criterion.
3. PCPs should be notified about case closure per instructions in the MHD contract, section 2.11.1(f).	The compliance dropped from 20% (EQR 2020-BH CM) to 7% (EQR 2022-Autism CM)	**Low** The issue persists. A recommendation is stated in Table 5-5 (issue 3).
4. Home State Health should address all points listed under the MHD contract, section 2.11.1(e) while developing a care plan for each member.	Home State Health created a care plan template meeting all contractual requirements and utilized it for CM.	**High**
5. Home State Health initiates a process that tracks all the issues related to the MHD's pharmacy unit, from start to finish, including but not limited to: date/time of encounter; who spoke to whom (with titles/roles); name and Medicaid ID of the member for whom the communication/contact was made; issue discussed; and the specific outcome. Home State Health must use supporting documentation (e.g., fax, letters), collaborate with provider services to improve communication with the MHD Pharmacy unit, and utilize the demographic reports sent by the MHD and the providers (of record) to locate the member for CM services.	Home State Health educated staff members on outreaching the pharmacies, including the member on the calls, and utilizing Home State Health's pharmacy director to assist when needed. While Home State Health continues to build on that relationship, there has been an improvement in communication and collaboration over the past two years.	**High** PTM did not see any notation of pharmacy issues in the MRR.

The degree of Home State Health's response to the previous year's (EQR 2020) recommendations was assessed to be 50% (Table 5-8).

Table 5-8. Scoring Degree of Response						
Total	High	=	2	×2	=	4
	Medium	=	0	×1	=	0
	Low	=	2	×0	=	0
Numerator	Score Obtained					4
Denominator	Total Sections	=	4	×2	=	8
Overall Score= Low						**50%**

5.3 Findings, Analysis, Conclusions, and Recommendations: Healthy Blue

CM Data for CY 2021: PTM obtained the following CM data from Healthy Blue.

Medicaid Managed Care members enrolled (year-end) = 340,239
Total members in active CM or care coordination programs = 2,795
Number of members identified for CM in the focus areas/enrolled =
- Foster Care: 3,264/82
- Autism: 261/67
- EBLLs: 132/37

CM staff available =
- Foster Care: Seven care managers, seven personal guides (vacancies included)
- Autism/Behavioral Health: Five care managers, two outreach care specialists (vacancies included)
- EBLLs: 3 care managers (including vacancies)

Average case load =
- Foster Care: Active cases 35 per day and an additional 200 cases for monitoring, with follow-up every 60-90 days.
- Autism/Behavioral Health: Thirty cases (maximum 40) per day.
- EBLLs: Active cases 35-50 per day (blood lead level-10 µgm/dl or higher); and 110-130 cases with a lead level of 5-9.9 µgm/dl.

Findings

Policies and Procedures Review

Healthy Blue submitted the following policies and procedures (Table 5-9). Upon review, PTM assigned a score of Fully Met (🟢), Partially Met (🟡), or Not Met (🔴) based on the requirements mandated by the MHD contract.

Table 5-9. Findings: Policies and Procedures Review

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
1. A description of the system for identifying, screening, and selecting members for CM services.	●	HB MO Foster Care Program-Care Management Programming, Elevated Blood Lead Level-Care Management MO, Complex Case Management 2022 Program Description, Population Assessment - MO, GBD-CM-019MO Case Management Program Case Identification, GBD-CM-111 Associate Roles, Functions and Safety, Face-to-Face Intervention-MO.
2. Provider and member profiling activities.	●	Access to Behavioral Health, HB MO Foster Care Program-Care Management Programming, Over/Under-Utilization of Services-MO.
3. Procedures for conducting provider education on CM.	●	Provider Orientation, Face-to-Face Intervention-MO.
4. A description of how claims analysis will be used.	●	HB MO Foster Care Program-Care Management Programming, Provider Orientation, Complex Case Management 2022 Program Description.
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in developing the care plan.	●	HB MO Foster Care Program-Care Management Programming, HB MO Foster Care Program-Quality- Member Outcomes, Complex Case Management 2022 Program Description, GBD-CM-002MO Care Manager Role and Function in Complex Care Management, GBD-Care Manager Planning and Facilitation-MO.
6. A process to ensure integration and communication between physical and behavioral health.	●	Internal CM Referral Process, Complex Case Management 2022 Program Description, Integrated Care Management-MO.

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●	Internal CM Referral Process, Complex Case Management 2022 Program Description, Integrated Care Management-MO.
8. A process to ensure that care plans are maintained and updated as necessary.	●	HB MO Foster Care Program-Care Management Programming, HB MO Foster Care Program-Quality- Member Outcomes, GBD-CM-111 Associate Roles, Functions, and Safety.
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	●	Complex Case Management 2022 Program Description, GBD-CM-111 Associate Roles, Functions, and Safety.
10. Timeframes for reevaluation and criteria for CM closure.	●	Elevated Blood Lead Level-Care Management MO, GBD-CM-004MO Care Manager Monitoring, Follow-Up, and Evaluation, GBD-CM-103MO Care Manager Case Closure.
11. Adherence to applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	●	HB MO Foster Care Program-Care Management Programming, Complex Case Management 2022 Program Description, GBD-CM-002 MO Care Manager Role and Function in Complex Care Management.
12. A mechanism for feedback from youth in foster care or recently out of care and guardians/foster parents to inform processes and the healthcare visit schedule followed by the care managers for the individuals in foster care.	●	EPSDT Core Policy-MO, EPSDT Corporate Outreach and Monitoring-MO, HB MO Foster Care Program-Care Management Programming, HB MO Foster Care Program-Coordination with Health Homes, HB MO Foster Care Program-Quality- Member Outcomes, Systems Process-Foster Care Coordinators.
13. Additional CM Information.	●	GBD-Care Management Clinical Documentation, Member Satisfaction Survey-MO,

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Met/ Not Met	Documents Submitted
		Preventive and Other Services Requiring Pay and Chase, GBD-CM-011MO Care Management Associate Training, GBD-HCM-006 Health Care Management-Clinical Training Compliance.
PTM Comments	Healthy Blue is fully compliant. Nil recommendations.	

Medical Record Review

Table 5-10 summarizes the medical records included in the study for each CM focus area.

Table 5-10. Medical Records in the Sample Study

	Foster Care CM	Autism CM	EBLLs CM
Sample size/oversample	30	0	22
Exclusions	10	0	2
Medical records reviewed	20	20	20
Cases closed/goals met	4	11	3
Active cases (in progress)*	2	5	17

*HB does not close FC cases; they remain in passive-monitoring status for follow-up every 90 days.

Table 5-11 identifies medical records' compliance with the criteria required in the MHD contract, as applicable to all three CM focus areas.

Table 5-11. Compliance (%) with CM Criteria

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Placement in Foster Care	25	N/A	N/A
Referral/Notification (State)	85	N/A	N/A
Referral/Notification (all sources)	95*	100	100
Initial screening within 72 hours of placement (within 24 hrs. for younger, chronic condition (by provider)	5	N/A	N/A
Initial Blood Lead Level	N/A	N/A	100
Offer CM (Assessment) within 30 days of notification from the State (new member)*	0		
Offer CM (Assessment) within 30 days or within the contractual	40	100	60

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
timeframe for EBLLs from any source notification			
Medical history	100	100	100
Psychiatric history	100	100	100
Developmental history	100	100	100
Psychosocial/Trauma history	95	100	100
Dental health	100	N/A	N/A
Legal issues	90	100	100
Education needs	75	N/A	N/A
Immunization history	75	N/A	N/A
Follow-up assessment in 60-90 days of placement (by a provider)	10	N/A	N/A
Health Encounters-three in the first three months of foster care (all ages)-by a provider	15	N/A	N/A
Assessment within 30 days of discharge from hospital or rehab. facilities after readmission or stay of more than two weeks or three ED visits in a quarter/within five business days of admission to a psychiatric hospital or substance use treatment program	67	25	N/A
Confirmatory venous lead level within the contractual timeframe	N/A	N/A	95
Family encounter#	N/A	N/A	95
Follow up Family encounter#	N/A	N/A	90
Care plan	100	100	100
Care plan updated	100	100	100
Sharing health information with birth parents, guardians, attorney, court, and school/involved in the care plan	65	100	100
Progress notes (follow-up)	100	100	100
Lab tests/follow-up tests within timeframes for EBLLs	100	N/A	40
Provider treatment plan	35	55	100
Transfer	100	100	100
Monitoring services and care, medication adherence	100	100	100
Coordination and linking of services	100	100	100
Behavioral health services availed	100	N/A	N/A
Discharge plan	44	67	100**
PCP notification of case closure	6	7	100**

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Member closure letter	N/A	N/A	100**
Aggregate Score	**72**	**86**	**95**

Red highlighted figures (score < 75%) indicate areas for improvement.
*For informational purposes, not included in calculating the aggregate score.
**Small denominator (3 cases) as cases are not closed for UTC per the MHD's instructions.
Telephonic encounters replaced face-to-face encounters due to the Covid-19 pandemic.

Evaluation of Care Plan

Healthy Blue meets all the contractual requirements for creating a care plan based on the MHD contract, 2.11.1(e), listed earlier in this report (section 5.1). The care managers worked with the members and created goals based on the care gaps. Interventions were planned to close the gaps. The care plan was updated at least once a month; however, the frequency varied per the level of risk stratification. PTM does not have any issues to report.

5.3.1 Quality, Timeliness, and Access

Strengths. PTM concluded the following strengths from the MRR and staff interviews. (Domain: Quality, Timeliness, and Access to Care).

- Detailed care plan to include all aspects of care, e.g., education on medication adherence, the importance of diet and exercise to maintain optimal weight, recommending six-monthly dental visits, maintaining immunization schedules, well-child checkups, and preventive screenings.
- Monitoring for medication adherence in CyberAccess℠ (State's web-based, HIPAA-compliant tool that allows Healthy Blue to view drug utilization information in near real-time and pharmacy claims data extracts).
- Skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts. All feasible means were utilized for interaction with members, e.g., telephone, E-mail, virtual meetings, faxes, and mailings.
- Assigning members in Foster Care CM to personal guides for monitoring and follow-up every 90 days after the CM goals are met and cases are closed.
- Providing Comfort Kits that are intended to provide comfort to Foster Care members and foster parents. Members receive an age-appropriate Comfort Kit filled with essential items to help ease their transition into their new home. Foster Care parents receive educational information such as tip sheets, guides, checklists, and information on all available local resources.
- Providing four hours of supplemental tutoring offered through Educational Tutorial Services. The Foster Care students' skills grow in the three core areas: English, Mathematics, and Language Arts.

- Providing information about psychiatrists and counselors and behavioral therapy.
- Intensive family intervention services-Crisis Stabilization.
- Crisis line services.
- Linking to community resources, BH support services, therapists, financial assistance resources, child protective services, Kansas City, MO, Angels Program, and Tcare-guardian support program.
- Monitoring compliance with doctor's appointments.
- Providing nutritional and physical activity counseling resources.
- Availability of Nurse Line (nursing advice services round the clock, 24 x 7).

Weaknesses. PTM analyzed the MRR results and categorized the issues (weaknesses) in the domain of Quality, Timeliness, and Access to Care as follows (Tables 5-12 to 5-14). PTM provided recommendations for improving each issue.

Table 5-12. Foster Care CM Review: Weaknesses and Recommendations

Foster Care CM Weakness	Recommendation
1. Criterion: The date of placement of a child in Foster Care. **(Timeliness)** This information was not known to Healthy Blue for 75% of cases. Healthy Blue informed PTM that the State did not provide the placement dates. Healthy Blue's access to State Children's Division (CD) documentation system (FACES), which houses the information, is limited. Healthy Blue confirmed that their CM team did not collect the information from the CD system. Healthy Blue has subsequently trained its CM team to capture placement dates for all Foster Care members.	Healthy Blue must work with the MHD* and CD to receive the information on the placement of a child for COA 4 for effective CM (tracking initial screenings and health encounters by the providers).
2. Criteria: Initial screening within 72 hours/within 24 hours of placement for younger/preverbal children (by the providers); three encounters within the first three months of placement; and follow-up health assessment within 60-90 days of placement. **(Timeliness)** Healthy Blue did not track these criteria as the placement date was unavailable. Also, Healthy Blue informed PTM that they were not required to track and report these criteria to the MHD from the last quarter of CY 2021. (An email communication from the MHD, dated Oct 19, 2021,	Healthy Blue and the MHD* must work towards addressing these three criteria. The MHD* must amend its managed care contract, section 2.11.1(d)(3), if the MHD does not require Healthy Blue to report on these criteria.

Foster Care CM Weakness	Recommendation
was submitted by another MCO, also applicable to Healthy Blue.) Furthermore, Healthy Blue reported a communication from the MHD on Dec 19, 2018, that exempted the MCO from its accountability for reporting these criteria (documentation of this communication was not submitted).	
3. Criterion: Comprehensive assessment within 30 days of notification/enrollment. **(Timeliness)** Healthy Blue complied with the timeframe for 40% of cases when they received a notification from any referral source. Healthy Blue's compliance for assessing the Foster Care members following the State notifications was zero.	Healthy Blue must initiate its CM activity immediately upon notification from the State on the 834 file-COA 4 eligibles.
4. Criterion: Assessment. **(Quality)** Healthy Blue assessed its enrollees' immunization status and educational needs for 75% of cases. Trauma history was limited to merely asking about school or appointment scheduling difficulties faced in the past week.	The columns in the assessment should not be left blank even if the caregivers were unwilling to provide the information. The outcome of the encounter with the caregivers should be documented. Detailed trauma history should be elicited. Pre-schooling needs for younger children (below five years of age) must be elicited. The care managers should be trained to elicit immunization history from all available sources, e.g., State records, Children Division's case workers, PCPs, biological parents, foster parents, and guardians.
5. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)**	Healthy Blue should have a system of inpatient admission and discharge notifications from its providers so that timely

Foster Care CM Weakness	Recommendation
Healthy Blue was compliant for 67% of cases. Healthy Blue informed PTM that Behavioral Health treatment for COA 4 members is carved out to the MHD Fee-For-Service. Admission information is provided to Healthy Blue to initiate contact with the guardian for CM.	post-discharge assessments can be conducted. The MHD* must notify Healthy Blue about IP admissions and discharges in real-time so that Healthy Blue can outreach the caregivers for post-discharge assessment within the contractual timeframe.
6. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** Healthy Blue followed the requirements only in 35% of cases. The information was included in some of the letters mailed to the members. Healthy Blue reported that they had fax system issues in 2021, so the letters mailed to the members could not be saved. The problem was rectified in 2022.	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members or explained by the care managers when offering CM/creating a care plan. The care managers must document the date of communicating the requirements in the medical records.
7. Criterion: Health information sharing with parents, guardians, attorneys, courts, and schools. Healthy Blue documented access to members' care plans/sharing information with the caregivers only in 65% of cases. **(Access to Care)** Healthy Blue informed PTM that the information is routinely not shared with courts/attorneys unless specifically asked by the courts.	Healthy Blue should improve documentation in the medical records and address the requirement of sharing health information.
8. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** Access to members' care plans via the online provider portal/faxes documented in notes was in 35% of cases.	Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records.

Foster Care CM Weakness	Recommendation
Healthy Blue reported that they had fax system issues in 2021, so the letters mailed to the providers could not be saved. The issue was rectified in 2022.	
9. Criterion: Case Closure-Lost Opportunities **(Access to Care)** Healthy Blue could not complete the CM services in 56% of cases as they were unable to contact (UTC) the members or members refused CM. PTM noted in the MRR and the "Complex Care Management Description" document submitted by Healthy Blue that three outreach attempts are made within 14 days. After that, a case is closed as UTC unless instructed otherwise by the MHD, e.g., EBLL cases are not to be closed for UTC.	Maintain an accurate record of member contact numbers and motivate members by demonstrating the value of the CM program. This is the key to successful care coordination. PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts.** Additionally, Healthy Blue must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
10. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Healthy Blue submitted evidence in 6% of cases to suggest that PCPs were notified of the case closure/goals met and that the member had transitioned to monitoring status by a personal guide. Healthy Blue reported that they had fax system issues in 2021, so the letters mailed to the providers could not be saved. The issue was rectified in 2022.	Healthy Blue should comply with the criterion despite fax system issues. At a minimum, the care manager should document the date when the PCP was notified.

*Recommendations apply to the MHD.

**Adapted from the MHD contract, section 2.12.10 (d): The health plan shall make its best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

Table 5-13. Autism CM Review: Weaknesses and Recommendations

Autism CM Weakness	Recommendation
1. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** Healthy Blue complied for 25% of cases, as applicable. There was no post-discharge assessment for the remaining cases.	Healthy Blue's Hospital Care Transition (HCT) team should coordinate with the utilization management team and care managers for the discharge dates and latest member contact information. The HCT team should educate the members on the significance of CM to motivate participation. The care managers should be trained to promptly outreach the members for a post-discharge assessment or an assessment within five days of admission to a psychiatric hospital as applicable.
2. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** Healthy Blue followed the requirements only in 40% of cases. The information was included in some letters mailed to the members or in the progress notes. Healthy Blue reported that they had fax system issues in 2021, so the letters mailed to the members could not be saved. The issue was rectified in 2022.	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members. The care managers must be trained to document the requirements in the medical records.
3. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** Access to members' care plans via the online provider portal/faxes documented in notes was provided in 55% of cases. Healthy Blue reported that they had fax system issues in 2021, so the letters mailed to the providers could not be saved. The issue was rectified in 2022.	Care plans must be shared with the providers for their input via letters and online provider portals, and the care managers must be trained to document in the medical records.
4. Criterion: Case Closure-Lost Opportunities. **(Access to Care)**	Maintain an accurate record of member contact numbers and motivate members by demonstrating the value of

Healthy Blue could not complete CM, including discharge planning services, in 33% of cases. Out of these, 20% of cases were due to UTC. PTM noted in the MRR and the "Complex Care Management Description" document submitted by Healthy Blue that three outreach attempts are made within 14 days, and after that, a case is closed.	the CM program. This is the key to successful care coordination. PTM recommends closing no case before three months of unsuccessful outreach attempts. Additionally, Healthy Blue must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
5. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** Healthy Blue submitted evidence in 7% of cases to suggest that PCPs were notified of the case closure/goals met.	Cases not in active CM or closed due to goals met must be notified to the PCPs, and staff must be trained to document the date of communication with the PCPs in the medical records.

Table 5-14. EBLLs CM Review: Weaknesses and Recommendations

EBLLs CM Weakness	Recommendation
1. Criterion: Offer CM and complete an assessment within time frames for blood lead levels.* **(Timeliness)** All the members were assessed, but timeliness was achieved only in 60% of cases.	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers should obtain a date and time for future communications on initial contact.
2. Follow-up lab testing within the contractual time frame.** **(Timeliness)** Only 40% of Healthy Blue members had follow-up blood lead level testing within the timeframe. Of the non-compliant cases, 25% cases were non-compliant due to UTC.	Same Recommendation as above.

*EBLL: 10 to 19 µg/dL within one to three (1–3) business days; 20 to 44 µg/dL within one to two (1–2) business days; 45 to 69 µg/dL within twenty-four (24) hours; 70 µg/dL or greater – immediately.
**Follow up: 10-19 µg/dL – two to three (2-3) month intervals; 20-70+ µg/dL – one to two (1-2) month intervals.

5.3.2 Improvement from previous year

CM review was not assigned during the previous year (EQR 2021). Therefore, there were no recommendations. However, in EQR 2020, EQRO provided recommendations for Behavioral Health CM that apply to Autism CM. Table 5-15 shows the degree to which Healthy Blue responded to EQRO's recommendations from EQR 2020. PTM evaluated the actions taken by Healthy Blue and categorized them as High (Two points), Medium (One point), and Low (Zero points) defined in the previous section, 4.2.2 of this report.

Table 5-15. Healthy Blue's Response to Recommendations from EQR 2020

Recommendation	Action by Healthy Blue	Comment by EQRO
1. CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.	Healthy Blue's performance increased from 16% (EQR 2020) to 25% (EQR 2022).	**Medium** The issue persists. PTM has provided recommendations in Table 5-13 (issue 1)
2. The care plan should be shared with the providers and informed about how they can provide input or change the care plan.	This criterion was not evaluated in EQR 2020 per the MHD's instructions. In the EQR 2022, compliance was 55% for Autism CM.	**Medium** The issue persists. A recommendation is stated in Table 5-13 (issue 3).
3. PCPs should be notified about case closure per the MHD contract section 2.11.1(f) instructions. If there are issues due to the automation of their New CM Medical Record System, Healthy Blue should manually send a written notification to PCPs.	The compliance has marginally increased from 0 to 7% for Autism CM.	**Low** The issue persists. A recommendation is stated in Table 5-13 (issue 5).
4. Healthy Blue should address all points listed under the MHD contract, section 2.11.1(e) while developing a care plan for each member.	Healthy Blue created an elaborate care plan template meeting all the contractual requirements and utilized it for CM.	**High**

The degree of Healthy Blue's response to the previous year's (EQR 2020) recommendations was assessed to be 50% (Table 5-16).

Table 5-16. Scoring Degree of Response						
Total	High	=	1	×2	=	2
	Medium	=	2	×1	=	2

	Low	=	1	×0	=	0
Numerator	Score Obtained					4
Denominator	Total Sections	=	4	×2	=	8
Overall Score= Low						**50%**

5.4 Findings, Analysis, Conclusions, and Recommendations: UnitedHealthcare

CM Data for CY 2021: PTM obtained the following CM data from UnitedHealthcare.

Medicaid Managed Care members enrolled (year-end) = 258,581
Number of members identified for CM in the focus areas/enrolled =
- Foster Care: 962/894
- Autism: 290/290
- EBLLs: 40/40

CM staff available =
- Foster Care: 26
- Autism/Behavioral Health: 10
- EBLLs: 2

Average case load =
- Foster Care: 250
- Autism/Behavioral Health: 29
- EBLLs: 20

Findings

Policies and Procedures Review

UnitedHealthcare submitted the following policies and procedures (Table 5-17). Upon review, PTM assigned a score of Fully Met (●), Partially Met (●), or Not Met (●) based on the requirements mandated by the MHD contract.

Table 5-17. Findings: Policies and Procedures Review

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Score	Documents Submitted
1. A description of the system for identifying, screening, and selecting members for CM services.	●	Annual State Quality Improvement Program Evaluation (QAPI 2021), MCM 0012 Risk Stratification Process, MCM 001 Identification of High-Risk Members for

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Score	Documents Submitted
		Care Management, WPC Description FY 2022, Missouri Community and State (C & S) Foster Care High Risk and Emergency Procedures C & S Missouri Foster Care Emergency Room Diversion, Foster Risk Levels-Quick Guide.
2. Provider and member profiling activities.	●	QA003 Provider Profiling and Monitoring of Over and Under Utilization.
3. Procedures for conducting provider education on CM.	●	QAPI 2021, MCM 007 Informing and Educating Providers, 2022 Care Provider Manual, WPC Description FY 2022.
4. A description of how claims analysis will be used.	●	CM Program Description-ER Diversion Components, MCM 001 Identification of High-Risk Members for Care Management, WPC Description FY 2022.
5. A process to ensure that the primary care provider, member parent/guardian, and any specialists caring for the member are involved in developing the care plan.	●	QAPI 2021, MCM 002 Care Management Process, MO Foster Care Case Rounds.
6. A process to ensure integration and communication between physical and behavioral health.	●	QAPI 2021, CM Program Description-ER Diversion Components, WPC Description FY 2022.
7. A description of the protocols for communication and responsibility sharing in cases where more than one care manager is assigned.	●	QAPI 2021, CM Program Description-ER Diversion Components, WPC Description FY 2022.
8. A process to ensure that care plans are maintained and updated as necessary.	●	CM Program Description-ER Diversion Components, MCM 002 Care Management Process, NCM 002 Case Management Process.

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Score	Documents Submitted
9. A description of the methodology for assigning and monitoring Care Management caseloads that ensures adequate staffing to meet CM requirements.	🟡	Whole Person Care Description FY 2022, Staff and Case Load Balancing 2022-Writeup for EQRO*, Delegated Case Management/Care Coordination.
10. Timeframes for reevaluation and criteria for CM closure.	🟢	CM Program Description-ER Diversion Components, MCM 002 Care Management Process, NCM 002 Case Management Process, CS Foster Care-Care Management Program Status, Opening & Closing a Case – Foster/Adopt Program, Due Diligence Foster Adopt Program, MO Lead-01 MO Elevated Blood Lead Level Program.
11. Adherence to applicable State quality assurance, certification review standards, and practice guidelines as described in the contract.	🟢	CM Program Description-ER Diversion Components, MCM 002 Care Management Process, NCM 030 Clinical Practice Guidelines, WPC Description FY 2022.
12. A mechanism for feedback from youth in foster care or recently out of care and guardians/foster parents to inform processes and the healthcare visit schedule followed by the care managers for the individuals in foster care.	🟡	Writeup submitted for EQRO*, MCM 002 Care Management Process, 2022 Care Provider Manual, Member Handbook Aug 2021.
13. Additional CM Information.	🟢	MUM 003 Referrals, USCMM.06.10 Clinical Review Criteria, Foster/Adopt Program Community Care-Care Plan Documentation.

Policies and Procedures must include (MHD contract, section 2.11.1(c)(5):	Score	Documents Submitted
PTM Comments*	UnitedHealthcare must have policies and procedures as required by the MHD contract. A write-up created for EQRO submission must be incorporated into the standard operating policies and procedures.	

Medical Record Review

Table 5-18 summarizes the medical records included in the study for each CM focus area.

Table 5-18. Medical Records in the Sample Study

	Foster Care CM	Autism CM	EBLLs CM
Sample size/oversample	21	22	20
Exclusions	1	2	0
Medical records reviewed	20	20	20
Cases closed/goals met	3	12	11
Active cases (in progress)*	12	3	8

Table 5-19 identifies medical records' compliance with the criteria required in the MHD contract, as applicable to all three CM focus areas.

Table 5-19. Compliance (%) with CM Criteria

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Placement in Foster Care	75	N/A	N/A
Referral/Notification (State)	55	N/A	N/A
Referral/Notification (all sources)	55*	100	100
Initial screening within 72 hours of placement (within 24 hrs. for younger, chronic condition (by provider)	0	N/A	N/A
Initial Blood Lead Level	N/A	N/A	100
Offer CM (Assessment) within 30 days of notification from the State (new member)*	30		
Offer CM (Assessment) within 30 days or within the contractual timeframe for EBLLs from any source notification	30	90	25
Medical history	90	100	60
Psychiatric history	90	100	55

Evaluation Criteria	Foster Care CM	Autism CM	EBLLs CM
Developmental history	90	100	55
Psychosocial/Trauma history	90	100	55
Dental health	80	N/A	N/A
Legal issues	90	93	55
Education needs	90	N/A	N/A
Immunization history	40	N/A	N/A
Follow-up assessment in 60-90 days of placement (by a provider)	0	N/A	N/A
Health Encounters-three in the first three months of foster care (all ages)-by a provider	0	N/A	N/A
Assessment within 30 days of discharge from hospital or rehab. facilities after readmission or stay of more than two weeks or three Emergency Department (ED) visits in a quarter/within five business days of admission to a psychiatric hospital or substance use treatment program	50	100**	N/A
Confirmatory venous lead level within the contractual timeframe	N/A	N/A	90
Family encounter#	N/A	N/A	85
Follow up Family encounter#	N/A	N/A	72
Care plan	95	100	65
Care plan updated	95	100	65
Sharing health information with birth parents, guardians, attorney, court, and school/involved in a care plan	95	100	65
Progress notes (follow-up)	100	100	100
Lab tests/follow-up tests within timeframes for EBLLs	0	N/A	50
Provider treatment plan	35	35	55
Transfer	95	100	100
Monitoring services and care, medication adherence	95	100	95
Coordination and linking of services	95	100	85
Behavioral health services availed	94	N/A	N/A
Discharge plan	38	76	67
PCP notification of case closure	38	0	92
Member closure letter	N/A	N/A	0
Aggregate Score	**65**	**89**	**69**

Red highlighted figures (score < 75%) indicate areas for improvement.
*For informational purposes, not included in calculating the aggregate score.

**Small denominator (1 case)
Telephonic encounters replaced face-to-face encounters due to the Covid-19 pandemic.

Evaluation of Care Plan

UnitedHealthcare meets all the contractual requirements for creating a care plan based on the MHD contract, 2.11.1(e), listed earlier in this report (section 3.0). The care managers work with the members and create goals based on the care gaps. Interventions are planned to close these gaps. The care plan is updated at least monthly; however, the frequency varies from 30-90 days per the level of risk stratification. PTM does not have any issues to report.

5.4.1 Quality, Timeliness, and Access

Strengths. PTM concluded the following strengths from the MRR and staff interviews. (Domain: Quality, Timeliness, and Access to Care).

- A comprehensive assessment adopted from The National Child Traumatic Stress Network- Child and Adolescent Needs and Strengths (CANS) Manual was utilized for assessing all foster care enrollees. This overall assessment focuses on the detailed trauma history of foster care enrollees.
- Providing education to caregivers regarding trauma-informed services and safe sleep for babies.
- Assisting caregivers in locating physicians, specialists, and behavioral health resources,
- Scheduling medical and behavioral health appointments and answering questions about benefit plans. Monitoring compliance with doctors' appointments.
- Reminders for well-child appointments, dental, and vision appointments.
- Linking to community resources/BH support services/therapists.
- Monitoring for Medication adherence in CyberAccess^{sm} (State's web-based, HIPAA-compliant tool that allows UnitedHealthcare to view drug utilization information in near real-time.
- Providing nutritional and physical activity counseling resources.
- Availability of Nurse line (nursing advice services round the clock, 24 x 7).
- Assisting with transportation services (for all CM focus areas).
- Providing information about PCPs/Urgent Care/ED utilization.

Weaknesses. PTM analyzed the MRR results and categorized the issues (weaknesses) in the domain of Quality, Timeliness, and Access to Care as follows (Tables 5-20 to 5-22). PTM provided recommendations for improving each issue.

Table 5-20. Foster Care CM Review: Weaknesses and Recommendations

Foster Care CM Weakness	Recommendation
1. Criterion: Referral/Notification dates. **(Timeliness)** The State notifications were captured by UnitedHealthcare for 55% of cases, even though they received 834 files from the State daily.	UnitedHealthcare should maintain an accurate record of State notifications (834 files) about COA 4 members and start outreaching them for timely assessing the needs of COA 4 members.
2. Criteria: Initial screening within 72 hours/within 24 hours of placement for younger/preverbal children (by the providers); three encounters within the first three months of placement; and follow-up health assessment within 60-90 days of placement. **(Timeliness)** UnitedHealthcare did not track these criteria as the placement date was unavailable. Another MCO informed PTM that they were not required to track and report these criteria to the MHD for the last quarter of CY 2021 onwards. (An MHD e-mail communication dated Oct 19, 2021, was submitted by another MCO applicable to UnitedHealthcare.)	UnitedHealthcare and the MHD* must work towards addressing these three criteria. The MHD* must amend its managed care contract, section 2.11.1(d)(3), if the MHD does not require UnitedHealthcare to report on these criteria.
3. Criterion: Comprehensive assessment within 30 days of notification/enrollment. **(Timeliness)** UnitedHealthcare complied with the timeframe for 30% of cases.	UnitedHealthcare must initiate its CM activity immediately upon notification from the State on the 834 file-COA 4 eligibles.
4. Criterion: Assessment. **(Quality)** UnitedHealthcare assessed its enrollees' immunization status only for 40% of cases.	The care managers should be trained to elicit a history from all available sources, e.g., State records, Children Division's case workers, PCPs, biological parents, foster parents, and guardians. The information should be documented, and the assessment column should not be blank.
5. Criterion: Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission	UnitedHealthcare's Hospital Care Transition (HCT) team should coordinate with the utilization management

Foster Care CM Weakness	Recommendation
to psychiatric hospital/residential Substance Use treatment program. **(Timeliness)** UnitedHealthcare was compliant for 50% of cases. UnitedHealthcare informed PTM that they receive alerts from hospitals and State immediately at the time of IP admission.	team and care managers for the discharge dates and latest member contact information. The HCT team should educate the members on the significance of CM and motivate them. The care managers should be trained to promptly outreach the members for a post-discharge assessment or an assessment within five business days of admission to a psychiatric hospital as applicable.
6. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** UnitedHealthcare did not follow all the requirements for any member.	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members or explained by the care managers when offering CM/creating a care plan. The care managers must document the date of communicating the requirements in the medical records.
7. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** UnitedHealthcare complied only for 35% of cases. They informed PTM that some members do not have PCPs.	Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records. The members who do not have a PCP must be assigned to a PCP during the CM.
8. Criterion: Case Closure-Lost Opportunities **(Access to Care)**	Maintain an accurate record of member contact numbers and motivate members by demonstrating the value of the CM program. This is the

Foster Care CM Weakness	Recommendation
UnitedHealthcare could not complete CM services, including discharge planning, in 62% of cases as they were unable to contact (UTC) the members.	key to successful care coordination. PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts.** Additionally, UnitedHealthcare must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members' homes before closing a case for UTC.
9. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)** UnitedHealthcare notified providers in 38% of cases about the case closure/goals met.	A written notification to the PCPs must be provided to comply with the requirements. Staff must be trained to document the date of communication with the PCPs in the medical records.

*Recommendations apply to the MHD.

**Adapted from the MHD contract, section 2.12.10 (d): The health plan shall make its best effort to conduct an initial screening of each member's needs within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

Table 5-21. Autism CM Review: Weaknesses and Recommendations

Autism CM Weakness	Recommendation
1. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** Access to the member care plans linked to the online provider portal was provided via letters in 35% of cases. UnitedHealthcare stated the reason as a "sensitive diagnosis" for not sharing the care plan for the remaining cases.	Care plans involving behavioral health diagnosis must be shared with PCPs after obtaining written consent from members according to instructions in 42 CFR Part 2,* as applicable. The care managers must be trained to document the date of communication in the medical records.
2. Criterion: PCP notification about case closure explaining reason and condition at discharge. **(Quality, Timeliness)**	A written notification to the PCPs must be provided about case closure, the reason for closure, and the member's

UnitedHealthcare did not notify PCPs about case closure for any member (zero compliance). They stated the reason as a "sensitive diagnosis" for not sharing the case closure information.	condition at the time of discharge. The staff must be trained to document the date of communication with the PCPs in the medical records.

*42 Code of Federal Regulations Part 2: Confidentiality of SUD Patient Records

Table 5-22. EBLLs CM Review: Weaknesses and Recommendations

EBLLs CM Weakness	Recommendation
1. Criterion: Offer CM and complete an assessment within time frames for blood lead levels.* **(Timeliness)** The assessment was conducted for 55% of cases, but timeliness was achieved only in 25% of cases. PTM noted that the cases that did not have an assessment (9 of 20) were still in progress, or the cases were closed as "goals met."	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers should obtain a date and time for future communications on initial contact. The staff must be trained to promptly outreach members to conduct an assessment for all cases notified by the State or any referral source. (Exceptions: opt out of CM)
2. Criterion: Assessment. **(Quality)** Medical history was elicited for 60% of cases, and psychiatric, developmental, psychosocial, and legal history was elicited for 55% of cases. These are included in an assessment.	Same recommendation as above.
3. Follow-up lab testing within the contractual time frame.** **(Timeliness)** UnitedHealthcare complied with timeliness in 50% of cases.	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers should obtain a date and time for future communications on initial contact.
4. Family encounter (Face-to-Face/Telephonic) within two weeks of confirmatory venous blood lead level and second encounter within an interval of three months. **(Quality and Timeliness)** The first encounter was timely in 85% of cases and was not a significant issue; however, the success rate dropped to 72% within the timeframe.	To reduce the number of unsuccessful contact attempts and increase member participation, the care managers should obtain a date and time for future

	communications on initial contact.
5. Criteria: Care Plan (Quality, Timeliness, and Access to Care) A care plan was created for only 65% of cases. The care plan was left blank even though the progress notes are available for 100% of cases.	The staff must be trained to promptly outreach members to conduct an assessment and create a care plan for all cases notified by the State or any referral source. (Exceptions: opt out of CM)
6. Criterion: Inform the members about CM rationale and relationship, circumstances of disclosure to third parties, and complaint process. **(Quality)** None of the care plan or progress notes suggested UnitedHealthcare's compliance with the criterion (Zero compliance).	All the members enrolled for CM must be provided with the information listed in the criterion. The information can be included in the letters mailed to the members. The care managers must be trained to document the requirements in the medical records.
5. Criterion: Provider treatment plan/collaboration with providers ensuring health needs are assessed. **(Quality, Access to Care)** Providers were mailed letters with instructions to access care plans online via UnitedHealthcare's provider portal for 55% of cases.	Care plans must be shared with the providers for their input via letters, online provider portal, or faxes, and the care managers must be trained to document in the medical records.
6. Case Closure-Lost Opportunities **(Access to Care)** UnitedHealthcare could not complete the CM services, including discharge planning, in 33% of cases due to UTC.	Maintain an accurate record of member contact numbers and motivate members by demonstrating the value of the CM program. This is the key to successful care coordination. PTM recommends that any case should not be closed before three months of unsuccessful outreach attempts.** Additionally, UnitedHealthcare must check with the PCPs, Women, Infants, and Children (WIC), and other providers and programs and visit members'

	homes before closing a case for UTC.
7. Criterion: Member closure letter must include the date of discharge, the reason for discharge, lab results, member status, exit counseling (telephone number for member assistance, and the status of care plan goal completion. **(Quality, Access to Care)** UnitedHealthcare did not send a case closure letter to any member stating that it was not required.	The care managers must be educated to comply with the MHD contract, section 2.11.1(e)(5). They must send a case closure letter to the member, save a copy as evidence, and document it in the medical records.

**EBLL: 10 to 19 µg/dL within one to three (1–3) business days; 20 to 44 µg/dL within one to two (1–2) business days; 45 to 69 µg/dL within twenty-four (24) hours; 70 µg/dL or greater – immediately.
**Follow up: 10-19 µg/dL – two to three (2-3) month intervals; 20-70+ µg/dL – one to two (1-2) month intervals.

5.4.2 Improvement from previous year

CM review was not assigned during the previous year (EQR 2021). Therefore, there were no recommendations. However, in EQR 2020, EQRO provided recommendations for Behavioral Health CM that apply to Autism CM. Table 5-23 shows the degree to which UnitedHealthcare responded to EQRO's recommendations from EQR 2020. PTM evaluated the actions taken by UnitedHealthcare and categorized them as High (Two points), Medium (One point), and Low (Zero points), defined in the previous section, 4.2.2 of this report.

Table 5-23. UnitedHealthcare's Response to Recommendations from EQR 2020

Recommendation	Action by UnitedHealthcare	Comment by EQRO
1. UnitedHealthcare should include all the information pertaining to medical, psychiatric, developmental, psychosocial, and legal history in a single questionnaire to assess a member's needs.	UnitedHealthcare has included all components in the history to assess members' needs.	**High**
2. CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.	N/A	Hospitalization was not reported for any psychiatric diagnosis in the Autism sample selected for evaluation. So, this recommendation

		could not be assessed.
3. The care plan should be shared with the providers and informed about how they can provide input or change the care plan.	This criterion was not evaluated in EQR 2020 per the MHD's instructions. In the EQR 2022, compliance was 35% for Autism CM.	**Medium** The issue persists. A recommendation is stated in Table 5-21 (issue 1).
4. PCPs should be notified about case closure per instructions in the MHD contract, section 2.11.1(f).	The compliance dropped from 94% to zero for Autism CM.	**Low** The issue persists. A recommendation is stated in Table 5-21 (issue 2).
5. UnitedHealthcare should address all points listed under the MHD contract, section 2.11.1(e) while developing a care plan for each member.	UnitedHealthcare's care plan meets all the contractual requirements of care plan components.	**High**
6. UnitedHealthcare initiates a process that tracks all the issues related to the MHD's pharmacy unit, from start to finish, including but not limited to: date/time of encounter; who spoke to whom (with titles/roles); name and Medicaid ID of the member for whom the communication/contact was made; issue discussed; and the specific outcome. UnitedHealthcare must use supporting documentation (e.g., fax, letters), collaborate with provider services to improve communication with the MHD Pharmacy unit, and utilize the demographic reports sent by the MHD and the providers (of record) to locate the member for CM services.	UnitedHealthcare initiated the following actions to resolve the pharmacy issue: a. Instituted a formal standard operating procedure for care managers to make referrals to UnitedHealthcare's internal pharmacist. This streamlined the process and allowed the pharmacist to speak directly to the pharmacist at the MHD. b. An activity was added for "pharmacist consult," which allowed the care manager and the pharmacist to document in the system and thus in the member's chart for tracking the issue. c. A path for escalations was outlined. For any escalations, an email is	**High** PTM did not see any documentation of pharmacy issues in the MRR.

	sent to the direct care manager as well as UnitedHealthcare's leadership which starts either email or telephone outreach to the Pharmacy Lead at the MHD. UnitedHealthcare reported that its relationship with the MHD pharmacy has improved.	

The degree of UnitedHealthcare's response to the previous year's (EQR 2020) recommendations was assessed to be 70% (Table 5-24).

Table 5-24. Scoring Degree of Response						
Total	High	=	3	×2	=	6
	Medium	=	1	×1	=	1
	Low	=	1	×0	=	0
Numerator	Score Obtained					7
Denominator	Total Sections	=	5	×2	=	10
Overall Score= Medium						**70%**

5.5 Recommendations For MCOs

Table 5-25 displays PTM's recommendations (with numbers corresponding to the listed items) applicable to Home State Health, Healthy Blue, and UnitedHealthcare.

Table 5-25 Recommendations applicable (✓) for MCOs

Recommendation No:	Home State Health	Healthy Blue	UnitedHealthcare
1.	✓	✓	✓
2.	✓	✓	✓
3.	✓	✓	-

1. The MCOs must address all the weaknesses listed for CM focus areas in sections 5.2.1, 5.3.1, and 5.4.1 (as applicable to Home State Health, Healthy Blue, and UnitedHealthcare). Also, recommendations from the previous years scored as "Low" and "Medium" must be addressed (Tables 5-7, 5-15, and 5-23, as applicable to the MCOs).

2. The MCOs' CM teams utilize the Health Information Exchange (HIE) to increase coordination, reduce fragmentation and improve overall communication between care

providers. All Missouri Medicaid providers have been offered free HIE enrollment.

3. PTM recommends that Home State Health and Healthy Blue's children receive a complete mental health evaluation, including a trauma assessment, shortly after entering foster care. A mental health screening to assess suicide risk and acute mental health needs are important at the entry to care. A complete evaluation is best conducted after the child has had time to adjust to their new living situation and visitation with the family.[5]

[5] Health Care Issues for Children and Adolescents in Foster Care and Kinship Care 2015, American Academy of Pediatrics.

6.0 QUALITY STRATEGY: RECOMMENDATIONS FOR THE MHD

Per 42 CFR 438.364(a)(4), PTM is required to provide recommendations to the MHD on achieving their target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. Table 6-1 presents the State quality strategy elements per the CFR 438.340, the MHD's QIS 2021 goals, and the EQR activities required to be conducted per the EQRO contract. All the quality strategy elements listed in the 42 CFR 438.340 and the MHD's QIS goals were not included in the current EQRO contract for review. Hence, they are marked as "Not Applicable-N/A." PTM did not provide recommendations for activities outside the EQRO contract's scope.

Table 6-1. Quality Strategy Goals under EQRO contract

Quality Strategy Elements under 42 CFR 438.340	MHD's QIS Goals	EQRO Contract
Network adequacy and availability of service standards.		N/A
Examples of clinical practice guidelines.		This was covered and reported under compliance activity in EQR 2021.
State's goals and objectives for continuous quality improvement.	Goal 1-Ensure appropriate access to care. Goal 2-Promote wellness and prevention. Goal 3-Ensure cost-effective utilization of services. Goal 4-Promote member satisfaction with the experience of care.	Goal 1-Access to care is covered in a separate activity, "secret shopper survey," which is not a part of the Annual Technical Report. The survey was conducted from May 19-July 12, 2022, and results and recommendations were reported to the MHD. Goal 2-CHL and W30 measures are addressed in this report which is part of promoting wellness and prevention. Goal 3-N/A Goal 4-N/A

Performance measures.		It is covered in EQR 2022.
Performance improvement projects.		It is covered in EQR 2022.
Transition to care policy.		It is covered in the Compliance activity in current EQR 2022 under regulation 42 CFR 438.208 (457.1230(c)) and in CM activity.
Evaluation of health disparities.		N/A
Intermediate sanctions for MCOs for 42 CFR 438 Subpart I.		N/A
State's assessment of performance and quality outcomes achieved by PCCM entity.		N/A
Identification of persons who need LTSS or special healthcare needs.		N/A
Nonduplication of EQR activities.		N/A
Definition of significant change.		N/A

PTM provided the following recommendations to the MHD for the activities conducted per the EQRO contract.

6.1 Performance Improvement Projects

1. The MHD must clarify with the MCOs that they should implement system interventions only (MHD contract, section 2.18.8 (d)(1)) and not member/provider interventions. Per the CMS EQR protocol 1, it is expected that interventions associated with significant improvement will be system interventions (such as educational efforts, policy changes, or targeting additional resources). However, 42 CFR 438.330(d)(2) requires an MCO to implement interventions to improve access and quality of care. There is no emphasis on system interventions.

2. Formal one-on-one TA would help the MCOs close the gaps in knowledge of its approach to conducting a PIP. Training, assistance and expertise for designing, analyzing, and

interpreting PIP findings are available from the EQRO, CMS publications, and research reviews.

3. The MHD should require the MCOs to develop a specific PIP plan, including a timeline, SMART aim statement, names and credentials of team members conducting the PIP, key driver diagram, performance indicators (primary and secondary measures, variables), interventions planned, data collection plan by the first quarter of a given MY, for approval.

6.2 Performance Measures

1. The MHD should consider including other Medicaid measures from CMS Adult Core Set, Child Core Set, and Behavioral Health Core Set in addition to the measures required by HEDIS reporting.

2. The MHD should work with the MCOs to track, monitor, and measure the interventions taken to improve the performance of FUH, W30, and CHL and measures.

3. PTM recommends that the MHD sets targets for performance measures to measure the MCO's performance and not just focus on a percentage point increase from the previous year's rates.

6.3 Compliance with Medicaid and CHIP Managed Care Regulations

The following recommendations would improve the EQR process and findings.
1. The MHD contract with the MCOs should include a requirement to have policies and procedures for all the regulations covered under compliance review for the Medicaid and CHIP Managed Care Regulations.

2. The MHD collaborates with PTM and the MCOs on ways to increase the significance of the EQR.

3. Include PTM in quality-related meetings with the MCOs and the “EQR” as a standing agenda item.

4. The MHD should recommend that the MCOs focus on adopting documented and measurable ways to "ensure" that its providers and staff follow the regulations instead of relying on a member complaint system for issues. The MHD should guide the MCOs on conducting member and provider surveys in addition to the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

5. Identify ways PTM can assist the MCOs in meeting quality requirements, e.g., TA with quality improvement measures and models.

Specific recommendations based on the issues identified during the EQR are as follows:
1. The definition of "adverse benefit determination" in the MHD contract section 2.15.1(a)(5) states that "the failure of the MCO to act within the timeframes provided at section 2.12.16(c)(22) of the contract regarding the standard resolution of grievances and appeals." The MCOs are quoting the same statement in their policies. However, PTM noted that the MHD contract, section 2.12.16(c)(22), does not mention the timeframe. PTM recommends that the MHD replaces section 2.12.16(c)(22) with sections 2.15.5(e) and 2.15.6(l) of the MHD contract, which states the timeframes for resolution of grievances and appeals per 42 CFR 438.408(b) (1) and (2).

2. The MHD contract 2.15.5(e) states that "The health plan shall resolve each grievance and provide written notice of the resolution of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days of the filing date." The CFR states that the standard resolution of grievances may not exceed 90 calendar days when the MCO receives the grievance. PTM recommends that the MHD specifies an action they would take if the MCOs cannot resolve a grievance in 30 calendar days but has resolved it within 90 calendar days.

3. The following sections from the 42 CFR 438.238 Grievance and appeal system (Medicaid managed care) differ from the 42 CFR 457.1260 Grievance system (CHIP managed care). However, PTM noted that the MHD contract does not differentiate between the grievance and appeal system for Medicaid and CHIP members.

a. Definition of adverse benefit determination (42 CFR 438.400): For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network (N/A for CHIP).

b. CHIP enrollees have the right to request a State External Review in accordance with 42 CFR 457.1130 and 457.1260(b)(2)).

c. Continuation of benefits while an appeal is pending (42 CFR 438.420)-N/A CHIP.

d. CHIP does not require a State to pay for disputed services furnished while an appeal is pending (42 CFR 438.424).

PTM recommends that the MHD consider aligning the grievance and appeal system per the CHIP regulations.

4. The MHD must upgrade its Missouri Medicaid Information System to allow the MCOs to submit encounter data, including allowed and paid amounts, to its providers, as required per 42 CFR 438.242(c).

5. MHD contract section 2.13.2 (j) states that the MCO shall not submit provider-facing materials to the state agency for review and approval. These materials are coordinated between the MCO and the providers. PTM recommends that the MHD reviews certain provider-facing documents that impact members' care, e.g., the provider manual. During EQR 2022, several inaccuracies were noted while reviewing the information presented in the provider manual corresponding to a regulation.

6. Per the MHD contract, section 2.18.8(c), regarding the credentialing and re-credentialing process, the MCOs are required to provide the state agency with the Social Security Number (SSN) of the providers.
UnitedHealthcare informed PTM that the MHD does not require the SSN of the providers as the providers are identified using their National Provider Identifier (NPI). They clarified the requirement from the MHD telephonically. The MO HealthNet Demographic Layout (Excel) submitted by UnitedHealthcare does not have an SSN field. If the information provided by UnitedHealthcare is correct, then PTM recommends that the MHD provides written clarification on the requirement and amend the contract to replace SSN with NPI. (Note: PTM noted that the Council for Affordable Quality Health Care (CAHQ) Universal Credentialing Data Source Form (UCDS) utilized by UnitedHealthcare for credentialing the providers has a field for SSN).

6.4 Care Management Program

Below is the list of all recommendations applicable to the MHD regarding the CM Program.

1. Criterion: The date of placement of a child in Foster Care.
PTM recommends that the MHD works with the Children's Division (state agency) to provide information to the MCOs so that the MCOs can track initial screenings and health encounters by the providers per the AAP guidelines for the Foster Care CM.

2. Criteria: Initial screening within 72 hours (within 24 hours of placement for younger/preverbal children) by the providers; three encounters within the first three months of placement; and follow-up health assessment within 60-90 days of placement. The MHD must amend its managed care contract, section 2.11.1(d)(3), if the MHD does not require the MCOs to report on these criteria based on the information provided by the MCOs to PTM during the site meetings. An MHD's email dated Oct 19, 2021, stated that the criteria were not required to be tracked by the MCOs.

3. Criterion: CM Assessment within 30 days of discharge from hospital or rehabilitation facilities after readmission or stay of more than two weeks or three emergency room visits in a quarter/within five business days of admission to psychiatric hospital/residential Substance Use treatment program.
PTM recommends that the MHD notify the MCOs about IP admissions and discharges in real time so that the MCOs can contact caregivers for post-discharge assessment within the contractual timeframe. (Note: One of the MCOs informed PTM that Behavioral Health treatment for COA 4 members was carved out to the MHD Fee-For-Service. Admission information was provided to the MCO to initiate contact with the guardian.)

4. Criterion: CM Assessment within five business days of admission to psychiatric hospital/residential treatment program.
PTM recommends a change in the criteria by replacing "admission" with "discharge" and "business days" with "calendar days." Members may not be in a mental state to engage with care managers within five days of admission. The MCOs may have several holidays/non-business days at the corporate level, which may delay members' care.

5. Case Closure Notification: The MHD contract section 2.11.1(f) states that a PCP must be notified in writing of all instances of children discharged from CM and the reason for discharge. The MHD should clarify whether the PCP notification requirement is limited to children (specify age limit) only and not applicable to older members.

6. The MHD should provide a minimum duration for the MCOs' care managers to continue to attempt to contact members before a case is closed for "UTC."

7. The MHD should consider setting benchmarks and incentives for critical clinical criteria in the Foster Care CM program, which can serve as a driving force for the MCOs to improve their efforts toward member outcomes.

8. Federal legislation, the Fostering Connections to Success and Increasing Adoptions Act (Pub L No.110-351 [2008]), requires that states, in consultation with pediatricians and other health experts, develop systems for health oversight and coordination for children in foster care. This act outlines the important pieces of coordinated care: periodic health assessments, shared health information, provision of care in the context of a medical home, and oversight of prescription medications (particularly psychotropic drugs).

9. The MHD should encourage the utilization of HIE. This would facilitate coordinated care, notifications to PCPs, documentation requirements, and increase reporting of quality health indicators.